1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9585

CERTIFICATE OF DEATH

09559

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 23 Hagerstown
d. STREET ADDRESS: 735 Interval Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Blanche — Middle: Elizabeth — Last: Anderson

4. DATE OF DEATH: Month: Aug. — Day: 1 — Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Oct 2 1890

9. AGE (In years last birthday): 68 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Md. Hagerstown Wash. Co

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George M. Johnson

14. MOTHER'S MAIDEN NAME: Alice Elizabeth Buser

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ------

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Mrs. O. S. Potter 735 Intervak Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] Hagerstown Md.

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hemolytic anemia with splenomegaly — Interval between onset and death: Indefinite
292.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(b) Arteriosclerotic heart disease — 5 yr.
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1956, 19__ to Aug. 1, 19 59, that I last saw the deceased alive on August 1, 1959, and that death occurred at 8P. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: B B Kneisley M.D.
ADDRESS (Street, city or town, state): 148 West Washington St.,
DATE SIGNED: 8/3/59
PHYSICIAN'S NAME (Type): Dr. B. B. Kneisley — Hagerstown, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug 4/59
22c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cem.
22d. LOCATION (City, town or county) (State): Hagerstown, Md Washington Co

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Andrew K. Coffman Hagerstown, Md.

24a. REC'D BY REGISTRAR — DATE: AUG 6 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

TO HOSPITAL **ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hou ter death. Page 4 may be reta by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10712 **CERTIFICATE OF DEATH** 09560

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown / c. LENGTH OF STAY IN 1b 3 weeks	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wash. Co. Hospital	d. STREET ADDRESS 901 Potomac Ave., / e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

081

3. NAME OF DECEASED (Type or print) First: Lucretia Middle: Stine Last: Athey

4. DATE OF DEATH Month: 8 Day: 25 Year: 1959

5. SEX female | 6. COLOR OR RACE white | 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 8. DATE OF BIRTH Oct. 29, 1886 | 9. AGE (In years last birthday) 72 yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | 10b. KIND OF BUSINESS OR INDUSTRY home | 11. BIRTHPLACE (State or foreign country) Willow Hill, Pa. | 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Edgar S. Bock | 14. MOTHER'S MAIDEN NAME Ellen Stine

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. none | INFORMANT Howard N. Athey Address Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Occlusion | 3 wks

332X

DUE TO (b) Arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

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20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19 | 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 1954 to Aug 25 1959, that I last saw the deceased alive on Aug 25 1959, and that death occurred at 3:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE D Boyer M.D. ADDRESS (Street, city or town, state) DATE SIGNED 8-26-59

1

PHYSICIAN'S NAME (Type) Dr. D. J. Boyer

22a. BURIAL, CREMATION, REMOVAL (Specify) burial | 22b. DATE THEREOF 8-28-59 | 22c. NAME OF CEMETERY OR CREMATORY Rest Haven | 22d. LOCATION (City, town, or county) Hagerstown (State) Md.

23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss ADDRESS Hagerstown, Md. | 24a. REC'D BY REGISTRAR DATE AUG 28 '59 | 24b. REGISTRAR'S SIGNATURE Arthur E. Kraus

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9586 Dr Kehne 09561

CERTIFICATE OF DEATH

Reg. Dist. No. 302

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY Washington MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown
c. LENGTH OF STAY IN 1b 10 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Co. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown.
d. STREET ADDRESS 417 Indiana Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒X

3. NAME OF DECEASED (Type or print) First: Samuel Middle: Aaron Last: Beard
4. DATE OF DEATH Month: Aug. Day: 14, Year: 1959
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: April 11, 1885
9. AGE (In years last birthday): 74 yrs. IF UNDER 1 YEAR Months: Days: IF UNDER 24 HRS. Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Conductor
10b. KIND OF BUSINESS OR INDUSTRY: W.M.R.R.
11. BIRTHPLACE (State or foreign country): Miami Co. Peru Indiana
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Lewis Beard
14. MOTHER'S MAIDEN NAME: Susan CARBAUGH
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 705-10-5272
17. INFORMANT: Mrs Myrtle Beard Address: 417 Indiana Ave. Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Pulmonary insufficiency	7days
002X DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Pulmonary tuberculosis, far advanced, active	11 yrs
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerotic heart disease
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour: o. m. p. m. Month: Day: Year: 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 4 August 59 to 14 August 1959, that I last saw the deceased alive on 14 August 1959, and that death occurred at 3:40 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John H. Kehne M.D. ADDRESS (Street, city or town, state): 131 W. Washington St. Hagerstown, Md. DATE SIGNED

PHYSICIAN'S NAME (Type): John H. Kehne M.D. 15 Aug. 1959

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug. 17/59
22c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery
22d. LOCATION (City, town, or county) (State): Hagerstown, Md. Washington Co

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Andrew K. Coffman Hagerstown, Md,
24a. REC'D BY REGISTRAR DATE: AUG 18 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Thaw

VS A15 (4) 15M 9/55

1

9587 **MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

09562

CERTIFICATE OF DEATH

Reg. Dist. No.

1. **PLACE OF DEATH**
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 2 months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 1500 Pennsylvania Ave. Chronic Disease Hospital

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 109 Park Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

15 26.2

091

3. **NAME OF DECEASED** (Type or print): First Eppie Middle Edna Last Bell

4. **DATE OF DEATH**: Month August Day 30 Year 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: Sept. 29, 1888
9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk-Treas. Dept.
10b. KIND OF BUSINESS OR INDUSTRY: Gov't - Retired
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Ulyses Magruder Ricketts
14. MOTHER'S MAIDEN NAME: Sarah Catherine Harding.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
INFORMANT: Sister Frances Ricketts
Address: Same as Item #2

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days
722.0
DUE TO (b): Rheumatoid Arthritis, Severe, Multiple — 25 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Malnutrition, Generalized Arteriosclerosis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that I attended the deceased from May 29, 1959, to August 30, 1959, that I last saw the deceased alive on August 29, 1959, and that death occurred at 4:30 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Evaristo R. Lardizabal M.D. — ADDRESS (Street, city or town, state): 1500 Pennsylvania AVE — DATE SIGNED: 8-30-59

PHYSICIAN'S NAME (Type): Evaristo R. Lardizabal — Hagerstown, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9-1-59
22c. NAME OF CEMETERY OR CREMATORY: Rockville Cemetery
22d. LOCATION (City, town, or county) (State): Rockville, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: BETHESDA, MD.
24a. REC'D BY REGISTRAR DATE: SEP 1 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 2 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9630 Item 2 FilmG248 9-3-59 et

CERTIFICATE OF DEATH

Reg. Dist. No. 09563

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, Bonnesboro
c. LENGTH OF STAY IN 1b: 4 Years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Fahrney-Keedy Memorial Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. Penna. — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, Boonsboro Waynesboro
d. STREET ADDRESS: 223 South Church St. Fahrney-Keedy Memorial Home
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
S.	Allison	Benedict	August	27,	1959

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
M	W		10/23/68	90 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired, Machinist		Near Mercersburg Pa.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
James Benedict	Sarah Keller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No		Mrs. Elizabeth B. Kunz, San Mar Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cancer of prostate — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs.
DUE TO
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO
(c)

177X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from August 13, 1959 to Aug 27, 1959 that I last saw the deceased alive on Aug. 26, 1959, and that death occurred at 3A M, from the couses and on the dote stoted above.

ACTUAL SIGNATURE: G.W. Wilson M.D. — ADDRESS (Street, city or town, state): Boonsboro — DATE SIGNED: 8/27/59

PHYSICIAN'S NAME (Type): G. W. Wilson Md.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	8/29/59	Green Hill	Waynesboro Franklin Pa.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Walter Y. Grove, Waynesboro Pa

24a. REC'D BY REGISTRAR DATE: AUG 31 59

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

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FOR STATE HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9631 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

09564 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL- Wilson
c. LENGTH OF STAY IN 1b: 1 ½ Months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Clearspring R.F.D. #1

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. State: Maryland — b. County: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X RURAL-Charleton
d. STREET ADDRESS: Big Pool R.F.D. #1
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First CHARLES — Middle FRANKLIN — Last BOPPE
4. DATE OF DEATH: Month August — Day 18 — Year 1959
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: June 29, 1944
9. AGE (In years last birthday): 15 yrs.
IF UNDER 1 YEAR: Months 1 — Days 19
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student-Farmer
10b. KIND OF BUSINESS OR INDUSTRY: In school-Farming
11. BIRTHPLACE (State or foreign country): Near Big Spring, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Richard H. Boppe
14. MOTHER'S MAIDEN NAME: Clara Burkett

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mr. Richard H. Boppe — Address: Big Pool, RFD #1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 835X
DUE TO (b): Fractured Cervical Spine — instant
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Farm tractor upset caught beneath steering Wheel
20c. TIME OF INJURY: Hour 4:30 p. m. — Month, Day, Year 8-18-59
20d. INJURY OCCURRED: While at work [ ] Not while at work [X]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Farm
20f. (City or town) Clearspring (County) Washington (State) Md.

21. I certify that I took charge of the remains described above, held on Autopsy [ ], Inspection [X], Inquiry [ ], and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: A. E. W. Dietz M.D.
EXAMINER'S NAME (Type): A. E. W. Dietz Jr.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
DATE SIGNED: 8/19/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug. 22, 1959
22c. NAME OF CEMETERY OR CREMATORY: St. Paul Cemetery
22d. LOCATION (City, town, or county) (State): Near Clearspring, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Albert L. Leap — ADDRESS: Williamsport, Md
24a. REC'D BY REGISTRAR DATE: AUG 20 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Hawes

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate omitting the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 2/57

1

9588

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09565

Reg. Dist. No. 302

M

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 807 Hamilton Blv'd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Paul — Middle: Humrichouse — Last: Byer

4. DATE OF DEATH: Month: Aug. — Day: 17 — Year: 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan. 12, 1898
9. AGE (In years last birthday): 61 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanical Engineer
10b. KIND OF BUSINESS OR INDUSTRY: Potomac Edison
11. BIRTHPLACE (State or foreign country): Co. Hagerstown, Md.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Edgar H. Byer
14. MOTHER'S MAIDEN NAME: Clara Humrichouse

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): W.W. #1
16. SOCIAL SECURITY NO.: 214-10-5304
17. INFORMANT: Rev. Paul Byer, Wyomissing, Pa. — Address

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 420.0
DUE TO (b): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: one hour
DUE TO (c): Cardiac Arrhythmia Heart Dis. — 2 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: [signature] M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): J. F. Whitmore Jr.
DATE SIGNED: 8/20/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/20/59
22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
22d. LOCATION (City or town or county) (State): Washington Co Hagerstown, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Andrew K. Coffman — ADDRESS: Hagerstown, Md.
24a. REC'D BY REGISTRAR DATE: AUG 19 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, using the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the County Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9589

CERTIFICATE OF DEATH

09566

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: 232 N. Locust St.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 232 N. Locust St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: Thomas — Last: Carson

4. DATE OF DEATH: Month: August — Day: 20 — Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 20, 1897

9. AGE (In years last birthday): 62 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Repairman

10b. KIND OF BUSINESS OR INDUSTRY: City of Hag.

11. BIRTHPLACE (State or foreign country): Hagerstown Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Walter L. Carson

14. MOTHER'S MAIDEN NAME: Hannah Mc Coy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW 1

16. SOCIAL SECURITY NO.: 214-09-8636

INFORMANT: Mrs. Myrtle Carson — Address: Hagerstown Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o): Auricular Fibrillation — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs

420.0

DUE TO (b): arteriosclerotic heart disease — 5 yrs

Conditions, if ony, which gave rise to immediate couse (o), stoting the underlying couse lost.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o): Pulmonary Emphysema

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 5, 19 59 to Aug 20, 19 59 that I last saw the deceased alive on Aug 20, 19 59, and that death occurred at 5 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Paul Harrison M.D. — ADDRESS (Street, city or town, state): 318 N. Potomac St. — DATE SIGNED: 5-21-59

PHYSICIAN'S NAME (Type): Paul Harrison, M. D. — Hagerstown, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8-20-59

22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

22d. LOCATION (City, town, or county) (State): Hagerstown Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Scott F. Minnich & Son — ADDRESS: Hagerstown Md.

24a. REC'D BY REGISTRAR DATE: AUG 24 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9590

09567

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH
o. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Western Maryland State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE: Virginia — b. COUNTY: Albemarle
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Greenwood 83 X-3
d. STREET ADDRESS: none
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN — Middle ALBERT — Last CHEAPE

4. DATE OF DEATH: Month AUGUST — Day 28 — Year 1959

5. SEX: male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: unknown about
9. AGE (In years lost birthday): 78 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Inventor
10b. KIND OF BUSINESS OR INDUSTRY: self employed
11. BIRTHPLACE (State or foreign country): Kamby, Ceylon
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Henry Cheape
14. MOTHER'S MAIDEN NAME: Kathleen Sophie Hambrough

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
INFORMANT Address: Mrs. Malvina Terrell Cheape Charlottesville, Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): LOBULAR PNEUMONIA RIGHT LOWER LOBE — INTERVAL BETWEEN ONSET AND DEATH: 6 DAYS.
527.1
DUE TO (b): CORONARY ATHEROSCLEROSIS SEVERE — UNKNOWN
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): PULMONARY EMPHYSEMA — UNKNOWN

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): CEREBRAL VASCULAR ACCIDENT
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from MAY 7, 1958, to AUG. 28, 1959, that I last saw the deceased alive on AUGUST 28, 1959, and that death occurred at 6.30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: George Bercu M.D. — ADDRESS (Street, city or town, state): 1500 PENNSYLVANIA AVE. — DATE SIGNED: 8/28/59
PHYSICIAN'S NAME (Type): DR. GEORGE BERCU — HAGERSTOWN, MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: 8/29/1959
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
22d. LOCATION (City, town, or county) (State): Washington D. C.

23. FUNERAL DIRECTOR'S SIGNATURE: Suter-Rouzer Funeral Home — R. Franklin Rouzer
ADDRESS: Hagerstown, Maryland
24a. REC'D BY REGISTRAR DATE: SEP 1 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9591

CERTIFICATE OF DEATH

09568

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

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1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 24 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Pa. — b. COUNTY: Franklin ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Waynesboro 75x-3
d. STREET ADDRESS: 119 C. V. Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Francis — Middle: Reno — Last: Cline

4. DATE OF DEATH: Month: August — Day: 21 — Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11/13/1900

9. AGE (In years last birthday): 58 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter, Frick Co.

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Pondsville Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel Cline

14. MOTHER'S MAIDEN NAME: Hester Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 173-03-2871

17. INFORMANT — Address: Mrs. Francis R. Cline, 119 C.V. Ave., Waynesbor Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respiratory and circulatory failure. — INTERVAL BETWEEN ONSET AND DEATH: At least 6 weeks.
340.3
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Chronic granulomatous leptomeningitis.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ■

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 28, 1959, to August 21, 1959, that I last saw the deceased alive on August 20, 1959, and that death occurred at 5 a. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: A. F. Abdullah M.D. — ADDRESS (Street, city or town, state): 132 N. Potomac St., Hagerstown, Md. — DATE SIGNED: 8/24/59

PHYSICIAN'S NAME (Type): A. F. Abdullah, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8/25/59

22c. NAME OF CEMETERY OR CREMATORY: Green Hill

22d. LOCATION (City, town, or county) (State): Waynesboro, Franklin Pa.

23. FUNERAL DIRECTOR'S SIGNATURE: Walter F. Shue — ADDRESS: Waynesboro Pa

24a. REC'D BY REGISTRAR — DATE: AUG 27 '59

24b. REGISTRAR'S SIGNATURE: Cynthia S. Krause

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9632

CERTIFICATE OF DEATH

09569

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sharpsburg Md RFD #2
c. LENGTH OF STAY IN 1b: 7 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): × Sharpsburg Md. RFD #2
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Carrie — Middle: Virginia — Last: Crampton

4. DATE OF DEATH: Month: Aug. — Day: 19 — Year: 19 59

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED [X] **NEVER MARRIED** [ ] **WIDOWED** [ ] **DIVORCED** [ ]

8. DATE OF BIRTH: Feb. 28 1897

9. AGE (In years last birthday): 62 yrs.

IF UNDER 1 YEAR: Months: 5 — Days: 22
IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Tilghmanton Md.

12. CITIZEN OF WHAT COUNTRY: U. S. A

13. FATHER'S NAME: Elias Potterfield

14. MOTHER'S MAIDEN NAME: Laura Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mr. Walter S. Crampton — Address: Sharpsburg Md. R. F. D. #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Portal hepatic cirrhosis — INTERVAL BETWEEN ONSET AND DEATH: 1 year
581.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] **OR CONTRIBUTING** [ ] **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sep. 1, 1958 to 8/19/59, that I last saw the deceased alive on 8/18/59, and that death occurred at 1 A; M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Walter H. Shealy M.D.
ADDRESS (Street, city or town, state): Sharpsburg, Md.
DATE SIGNED: 8/20/59

PHYSICIAN'S NAME (Type): Walter H. Shealy M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug. 21-59
22c. NAME OF CEMETERY OR CREMATORY: Mt. View Cemetery
22d. LOCATION (City, town, or county) (State): Sharpsburg Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Edith V. Leatherman
ADDRESS: Smithsburg Md.

24a. REC'D BY REGISTRAR DATE: AUG 24 '59
24b. REGISTRAR'S SIGNATURE: Carlton S. Kiang

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

9592

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Dr Ditto Jr.

Reg. Dist. No. 09570

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 3 Weeks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Co. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 70 East Antietam, Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ottie — Middle: Bell — Last: Crilley

4. DATE OF DEATH: Month: Aug. — Day: 4, — Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Sept. 18/1900

9. AGE (In years last birthday): 58 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Hancock Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Baker

14. MOTHER'S MAIDEN NAME: Mary Reed

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Richard L. Crilley — Address: 1534 Crest View Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 170X
DUE TO (b): Carcinoma Breast — INTERVAL BETWEEN ONSET AND DEATH: 1 Years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): c Metastasis to Lung

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: o. m. / p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1-3-59, to 8-4-59, that I last saw the deceased alive on 8-3-59, and that death occurred at 6:7 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: A. Ditto M.D. — ADDRESS (Street, City or town, State): Hagerstown Md — DATE SIGNED: 8/4/59

PHYSICIAN'S NAME (Type): A. DITTO JR

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Aug. 6/59

22c. NAME OF CEMETERY OR CREMATORY: Broadfording Cem.

22d. LOCATION (City, town, or county) (State): Broadfording, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: And rew K. Coffman — ADDRESS: Hagerstown, Md

24a. REC'D BY REGISTRAR DATE: AUG 6 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1 M

9593 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09571
Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH a. COUNTY: WASHINGTON — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: MARYLAND b. COUNTY: WASHINGTON
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN — c. LENGTH OF STAY IN 1b: 4 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X MOUSE TOWN - RURAL
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WASHINGTON COUNTY HOSPITAL	d. STREET ADDRESS: BOONSBORO MD. R. 2 — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
HUBERT	COLUMBUS	DAGENHART	AUGUST - 16 -		1959

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
MALE	WHITE		APRIL - 21 - 1888	71 yrs.	3	25		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
NONE	NONE	BOONSBORO WASH. CO. MD. U.S.A.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
AARON DAGENHART	SARAH DUTROW

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
NO	213-16-1555	MRS. MAUDE STAUBS HAGERSTOWN MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Congestive Heart failure — INTERVAL BETWEEN ONSET AND DEATH

420.0

DUE TO (b): Arteriosclerotic Heart Disease — 4 months

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Carcinoma of Liver — 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

2

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19			

21. I certify that I attended the deceased from March, 1959, to 8-16-, 1959, that I last saw the deceased alive on 8-16-, 1959, and that death occurred at 7 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: H H Secondari M.D. — ADDRESS (Street, city or town, state): 21 N. Main St, Boonsboro, Md — DATE SIGNED: 8/18/59

1

PHYSICIAN'S NAME (Type): JOSEPH SECONDARI

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
BURIAL	AUG. 19. 1959	BOONSBORO CEMETERY	BOONSBORO WASH. CO. MD.

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
John A. Bast	BOONSBORO MD.	AUG 24 '59	Arthur S. Thomas

1

Item 20,21 Film 248 9-9-59 ams

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9594 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

C 9572

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, using the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1. PLACE OF DEATH a. COUNTY: Washington — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If Institution, Address Institution) WASHINGTON a. STATE: Maryland — b. COUNTY: Washington
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown c. LENGTH OF STAY IN 1b:	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural Knoxville
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington County	d. STREET ADDRESS: 1 Weverton Hill e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Brenda	Lee	Darr	8	23	1959

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Female	White		7-17-1959	— yrs.	1	5		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	None	West Virginia	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Floyd F.Darr	Helen Cook

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No	None	Mr.Floyd F.Darr,R.F.D.#1,Knoxville,Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Suffocation due to aspiration — INTERVAL BETWEEN ONSET AND DEATH: 5 min

DUE TO (b): of vomitus

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 921.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
	Occurred during early morning feeding

20c. TIME OF INJURY Hour	Month, Day, Year	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
about a. m. p. m.	8/23/59 19		Home	Hagerstown	Wash,	Maryland

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Edward W. Ditto III M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): Edward W. Ditto III, M.D.

DATE SIGNED: 8/24/59

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	8-26-1959	Union	Lovettsville,Virginia

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
B. Lee Feete	Brunswick, Maryland	AUG 28 '59	Anna L Kines

9VVVVVVXVV

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9595

CERTIFICATE OF DEATH

Reg. Dist. No. 09573

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown, Maryland
c. LENGTH OF STAY IN 1b: 8yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Western Maryland State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown, Maryland.
d. STREET ADDRESS: 440 Park Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CHRISTOPHER Middle Columbus Last DENNIS

4. DATE OF DEATH: Month AUGUST Day 19 Year 1959

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Mar 10 1891

9. AGE (In years last birthday): 68 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Miner

10b. KIND OF BUSINESS OR INDUSTRY: Coal mine

11. BIRTHPLACE (State or foreign country): Montgomery County Tenn. USA.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Mederick Dennis

14. MOTHER'S MAIDEN NAME: Grace Brodus

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): World War 1

16. SOCIAL SECURITY NO.: 216-22-2646

INFORMANT: Mrs Hilda Dennis — Address: 440 Park Place

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): PERFORATED PEPTIC ULCER — INTERVAL BETWEEN ONSET AND DEATH: 6 HOURS
540.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): PULMONARY CONGESTION & EDEMA. CENTRAL NERVOUS SYSTEM SYPHILIS

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour ____ o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from APRIL 13, 1959, to AUGUST 19 1959, that I last saw the deceased alive on AUGUST 19, 1959, and that death occurred at 10.55 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: George Berch M.D. ADDRESS (Street, city or town, state): 1500 PENNSYLVANIA AVE. DATE SIGNED: 8/20/59

PHYSICIAN'S NAME (Type): DR. GEORGE BERCH. HAGERSTOWN MARYLAND.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8-22-1959
22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
22d. LOCATION (City, town, or county) (State): Hagerstown, Maryland.

23. FUNERAL DIRECTOR'S SIGNATURE: John R Watson Jr. ADDRESS: Hagerstown Md.

24a. REC'D BY REGISTRAR DATE: AUG 24 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9633

CERTIFICATE OF DEATH

Reg. Dist. No. 09574

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, Smithsburg

c. LENGTH OF STAY IN 1b: 34 Years

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Smithsburg #2

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Washington

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, Smithsburg

d. STREET ADDRESS: Smithsburg #2

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lionel — Middle: S. — Last: Diehl

4. DATE OF DEATH: Month: August — Day: 25 — Year: 19 59

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 11/1/1897

9. AGE (In years last birthday): 61 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Night Operator, S. Power Co.

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Near Smithsburg Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George C. Diehl

14. MOTHER'S MAIDEN NAME: Carrie Johns

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 214-10-4937

17. INFORMANT Address: Mrs. Lionel S. Diehl, Smithsburg Md., #2

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Generalized
DUE TO (b): Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 1 year
DUE TO (c):

199.2

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour o. m. / p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7-6-59, 19___, to 8-25-59 19___, that I last saw the deceased alive on 11:20 PM, 19___, and that death occurred at ___ M, from the causes and on the date stated above.

ACTUAL SIGNATURE: C W Lindeman M.D. — ADDRESS (Street, city or town, state): Waynesboro, Franklin Pa. — DATE SIGNED: 8-25-59

PHYSICIAN'S NAME (Type): C. W. Lindeman

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8/28/59

22c. NAME OF CEMETERY OR CREMATORY: Harbaugh's

22d. LOCATION (City, town, or county) (State): Smithsburg #2, Franklin Pa.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Walter L. Hose Waynesboro Pa.

24a. REC'D BY REGISTRAR DATE: AUG 28 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9634 Item 2 FilmG246 8-21-59 et 19575

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BOONSBORO RURAL
c. LENGTH OF STAY IN 1b: YEARS
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: FAHRNEY-KEEDY MEM. HOME

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): New Windsor RURAL
d. STREET ADDRESS: FAHRNEY KEEDY MEM. HOME
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First MARIANNA Middle ROYER Last ENGLER

4. DATE OF DEATH: Month AUG. Day 11 Year 1959

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: 4/21/1876

9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE

10b. KIND OF BUSINESS OR INDUSTRY: AT HOME

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: JEHU ROYER

14. MOTHER'S MAIDEN NAME: MARY MARGARET BOWERS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: MRS. H. PAUL HULL Address: NEW WINDSOR MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 month
420.1
DUE TO
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour ___ o. m. p. m. Month ___ Day ___ Year 19___

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 2 19 58 to Aug 11 19 59 that I last saw the deceased alive on Aug 10 19 59 and that death occurred at 11:30 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: G. W. LeVan M.D. ADDRESS (Street, city or town, state): Boonsboro DATE SIGNED: 8/11/59

PHYSICIAN'S NAME (Type): G. W. LeVan BOONSBORO Md

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 8/14/59

22c. NAME OF CEMETERY OR CREMATORY: PIPE CREEK CEM

22d. LOCATION (City, town, or county) (State): CARROLL COUNTY MD

23. FUNERAL DIRECTOR'S SIGNATURE: O. D. Hartzler Sons ADDRESS: New Windsor Md

24a. REC'D BY REGISTRAR DATE: AUG 14 59

24b. REGISTRAR'S SIGNATURE: Calvin S. Frank

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9596

CERTIFICATE OF DEATH

09576 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 2 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Carlock Conv. Home

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Penna
b. COUNTY: Cumberland
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Carlisle 75 x 3
d. STREET ADDRESS: 67 West North St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ida — Middle: J. — Last: Failor

4. DATE OF DEATH: Month: August — Day: 30 — Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12/15/871

9. AGE (In years last birthday): 87 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: House work

11. BIRTHPLACE (State or foreign country): Cumberland Co. Penna

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Levi Failor

14. MOTHER'S MAIDEN NAME: Mary Klinj

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: No

17. INFORMANT: Mrs. Mary Myers — Address: State Line Pa

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebro-Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 1 hr

DUE TO (b): Generalized Arterio-Sclerosis — 10 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Fracture of hip 1956 — 331X

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec, 19[illegible], to Aug, 19[illegible], that I last saw the deceased alive on 29 Aug, 1959, and that death occurred at [illegible] M, from the causes and on the date stated above.

ACTUAL SIGNATURE: [illegible] M.D. — ADDRESS (Street, city or town, state): Greencastle — DATE SIGNED: 8-31-59

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 9/3/59 — 22c. NAME OF CEMETERY OR CREMATORY: Newville Cemetery — 22d. LOCATION (City, town, or county) (State): Newville Cumberland, Penna

23. FUNERAL DIRECTOR'S SIGNATURE: Harold M. Zimmerman — ADDRESS: Greencastle, Pa

24a. REC'D BY REGISTRAR DATE: SEP 3 '59 — 24b. REGISTRAR'S SIGNATURE: Arthur S. Kinna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9635

CERTIFICATE OF DEATH

09577

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FUNKSTOWN
c. LENGTH OF STAY IN 1b: 15 YEARS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 37 WEST MAPLE ST.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X FUNKSTOWN
d. STREET ADDRESS: 37 WEST MAPLE ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First OMER — Middle EARL — Last FORREST

4. DATE OF DEATH: Month AUGUST — Day 22 — Year 1959

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: JUNE 25 1886

9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months 1 — Days 27
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MILLER-RETIRED

10b. KIND OF BUSINESS OR INDUSTRY: STICKELL MILL

11. BIRTHPLACE (State or foreign country): FRED. CO. MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JACOB FORREST

14. MOTHER'S MAIDEN NAME: CHARLOTTE WARD

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-09-3035

17. INFORMANT — Address: WAYNE FORREST - 37 W. MAPLE ST. FUNKSTOWN MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis
420.1
DUE TO
(b):
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Bronchial Asthma

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 22, 1959 to Aug 22, 1959 that I last saw the deceased alive on Aug 22, 1959 and that death occurred at 11:55 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Edward W. Ditto III M.D. — ADDRESS (Street, city or town, state): 217 W. Washington St. — DATE SIGNED: 8/27/59

PHYSICIAN'S NAME (Type): Edward W. Ditto III, M.D. Hagerstown, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: AUG. 25 1959
22c. NAME OF CEMETERY OR CREMATORY: LUTHERAN CEMETERY
22d. LOCATION (City, town, or county) (State): MIDDLETOWN FRED. CO. MD

23. FUNERAL DIRECTOR'S SIGNATURE: John W. Rust — ADDRESS: BOONSBORO MD.

24a. REC'D BY REGISTRAR DATE: AUG 27 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krantz

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9636

CERTIFICATE OF DEATH

09578 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL-Wilson
c. LENGTH OF STAY IN 1b: 1 week
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Gateway Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL-Indian Springs
d. STREET ADDRESS: Big Pool R.F.D. #1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Minnie Middle B. Last Forsythe
4. DATE OF DEATH: Month August Day 13 Year 1959
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 5,1872
9. AGE (In years last birthday): 87 yrs. IF UNDER 1 YEAR: Months 3 Days 8 IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (State or foreign country): St. Paul's Wash.Co.Md.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Jim Mills
14. MOTHER'S MAIDEN NAME: Mary Kensil
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: NONE
INFORMANT Address: Mr. Leonard Forsythe Big Pool, Md. RFD#1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): General arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH:
420.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Arteriosclerotic heart dis. — 10 yr
DUE TO
(c): Coronary thrombosis — 6 Mon

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Pneumonia - Lobar
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 13, 1959 to Aug 13, 1959 that I last saw the deceased alive on Aug 13, 1959, and that death occurred at 6 30 p M, from the causes and on the date stated above.
ACTUAL SIGNATURE: Edward W Ditto III M.D. ADDRESS (Street, city or town, state): 212 W. Washington St DATE SIGNED: 8/14/59
PHYSICIAN'S NAME (Type): Edward W. Ditto III, MD Hagerstown, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug. 16, 1959
22c. NAME OF CEMETERY OR CREMATORY: Shanktown E.U.B. Cemetery
22d. LOCATION (City, town, or county) (State): Near Big Pool Md.
23. FUNERAL DIRECTOR'S SIGNATURE: Albert L Leigh ADDRESS: Williamsport, Md
24a. REC'D BY REGISTRAR DATE: AUG 17 '59
24b. REGISTRAR'S SIGNATURE: Arthur L Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9597 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

09579

Reg. Dist. No. 302

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the City Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town]: Hagerstown
c. LENGTH OF STAY IN 1b: 57 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 817 Medway Road

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 817 Medway Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First FRANK; Middle; Last FRATIANNI

4. DATE OF DEATH: Month August; Day 6; Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: Oct. 29, 1888

9. AGE (In years last birthday): 70 yrs. — IF UNDER 1 YEAR: Months; Days — IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Barber

10b. KIND OF BUSINESS OR INDUSTRY: Barbershop

11. BIRTHPLACE (State or foreign country): Italy

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Danoto Fratianni

14. MOTHER'S MAIDEN NAME: Francesca Gallicchio

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No [If yes, give war or dates of service]

16. SOCIAL SECURITY NO.: 216-14-5593

17. INFORMANT: Francis W. Fratianni — Address: Hagerstown Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH:

420.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Artero Sclerotic Heart Disease — 10 mins

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m.; Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: [signature] M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): [illegible]

DATE SIGNED: 8/7/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8/8/1959

22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

22d. LOCATION (City, town, or county) (State): Hagerstown Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Charles M Rouzer — ADDRESS: Rouzer Funeral Home Hagerstown Md

24a. REC'D BY REGISTRAR DATE: AUG 21 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

VS. A15ME(5)
5M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

963?

09580
Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, ... the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page ... should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Antietam
c. LENGTH OF STAY IN 1b: 71 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Residence

2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Antietam
d. STREET ADDRESS: Harpers Ferry Rpad
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN — Middle WILLIAM — Last GARDNER

4. DATE OF DEATH: Month August — Day 25, — Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 9, 1888

9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Maintenance Man (Ret.)

10b. KIND OF BUSINESS OR INDUSTRY: Silk Mill

11. BIRTHPLACE (State or foreign country): Antietam, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Robert Gardner

14. MOTHER'S MAIDEN NAME: Mary Ellen Marshall

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
If yes, give war or dates of service: None

16. SOCIAL SECURITY NO.: 220-10-3647

17. INFORMANT: Mrs. Martha A. Gardner
Address: R.F.D.#1, Harpers Ferry, W.Va.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		
443X		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)	Hypertensive Cardio Vascular Dis	2 yrs
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Dr. Ewell Dietz Jr. M.D.
EXAMINER'S NAME (Type): DR EWELL DIETZ JR
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 8/26/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/28/59
22c. NAME OF CEMETERY OR CREMATORY: Samples Manor Cemetery
22d. LOCATION (City, town, or county) (State): Samples Manor, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: H. Donald Cackley
ADDRESS: Harpers Ferry, W.Va.
24a. REC'D BY REGISTRAR DATE: AUG 28 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraas

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9598

CERTIFICATE OF DEATH

Reg. Dist. No. 9581

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 80 YRS.
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: JACKSON CONV. HOME

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
d. STREET ADDRESS: 264 S. POTOMAC ST?
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First BERTHA — Middle ALICE — Last GRIFFENBERG

4. DATE OF DEATH: Month AUGUST — Day 6 — Year 19 59

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 11/13/1871

9. AGE (In years last birthday): 87 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: JOSEPH KROTZER

14. MOTHER'S MAIDEN NAME: NANCY JONES

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: MRS. THERESA B. McCUNE — Address HAGERSTOWN MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 45 mins.
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Enteritis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. / p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from August 6, 1959, to August 6, 1959, that I last saw the deceased alive on August 6, 1959, and that death occurred at 5:58p M, DST, from the causes and on the date stated above.

ACTUAL SIGNATURE: Wm. T. Layman, M.D. — ADDRESS (Street, city or town, state): 100 Professional Arts Bldg. — DATE SIGNED: 8/7/59

PHYSICIAN'S NAME (Type): William T. Layman, M.D. Hagerstown, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 8/8/59

22c. NAME OF CEMETERY OR CREMATORY: ROSE HILL CEM.

22d. LOCATION (City, town, or county) (State): HAGERSTOWN MD.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: W. J. Norment, Hagerstown, Md.

24a. REC'D BY REGISTRAR DATE: AUG 11 '59

24b. REGISTRAR'S SIGNATURE: Clarence E. Krause

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9638

CERTIFICATE OF DEATH

09582 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Washington MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boonsboro Md RFD 2
c. LENGTH OF STAY IN 1b: 1 yr.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: On Alternate RFD #40

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Boonsboro Md. RFD #2
d. STREET ADDRESS: On Alternate RFD #40
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒X

3. NAME OF DECEASED (Type or print): First Raleigh Middle Abram Last Griffith
4. DATE OF DEATH: Month Aug. Day 1 Year 1959
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan. 22 1882
9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months 6 Days 9 IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm Owner RET'D
10b. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (State or foreign country): Keedysville Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A
13. FATHER'S NAME: Abram Griffith
14. MOTHER'S MAIDEN NAME: Susan Wolf
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: None
INFORMANT: Mrs. Mary Griffith Address: Boonsboro Md. RFD #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH
450.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Generalized arteriosclerosis — 4 Yrs.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7-26-, 1959, to 7-31-1959, that I last saw the deceased alive on 7-31-, 1959, and that death occurred at 7A M, from the causes and on the date stated above.
ACTUAL SIGNATURE Joseph Secondari M.D. ADDRESS (Street, city or town, state) Boonsboro MD. DATE SIGNED 8-1-59
PHYSICIAN'S NAME (Type) Joseph Secondari, M.D. 21 N. Main St., Boonsboro, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug. 3 1959
22c. NAME OF CEMETERY OR CREMATORY: Mt. Lena Cemetery
22d. LOCATION (City, town, or county) (State): Mt. Lena Md.
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Albert K Leaf Williamsport, Md
24a. RECD BY REGISTRAR DATE: AUG 4 '59
24b. REGISTRAR'S SIGNATURE: Clinton S. Frantz

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

FOR STATE HEALTH DEPT.

9599

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09583

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate omitting the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 2/57

099

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): WASHINGTON CO. HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD. — b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X RURAL HAGERSTOWN
d. STREET ADDRESS: ROUTE 4
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First GREGORY — Middle LEE — Last GROVE

4. DATE OF DEATH: Month 8 — Day #31 — Year 1959

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED [ ] **NEVER MARRIED** [X] **WIDOWED** [ ] **DIVORCED** [ ]

8. DATE OF BIRTH: JULY 27, 1957

9. AGE (In years last birthday): 2 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): INFANT

10b. KIND OF BUSINESS OR INDUSTRY: INFANT

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: CLYDE M. GROVE

14. MOTHER'S MAIDEN NAME: SHIRLEY E. SPRENKLE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: CLYDE M. GROVE — Address: HAGERSTOWN, MD.

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 936.0
DUE TO (b): Suffocation by Hanging — INTERVAL BETWEEN ONSET AND DEATH: 3 minutes
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [X] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): Caught head between boards in corn crib

20c. TIME OF INJURY: Hour 11:00 a.m. — Month, Day, Year: 8-31-1959

20d. INJURY OCCURRED: While at work [ ] Not while at work [X]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Farm

20f. (City or town): Hagerstown (County): Washington (State): Md.

21. I certify that I took charge of the remains described above, held on Autopsy [ ], Inspection [X], Inquiry [ ], and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: H. E. Whitt M.D.
EXAMINER'S NAME (Type): H. E. WHITT JR.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
DATE SIGNED: 9/1/59

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 9/2/59
22c. NAME OF CEMETERY OR CREMATORY: ST. PAULS CEMETERY
22d. LOCATION (City, town, or county) (State): WASHINGTON CO., MD.

23. FUNERAL DIRECTOR'S SIGNATURE: JOHN F. CLARK
ADDRESS: CLEAR SPRING, MD.

24a. REC'D BY REGISTRAR DATE: SEP 4 '59
24b. REGISTRAR'S SIGNATURE: Clinton L. Frank

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9600

CERTIFICATE OF DEATH

09584
Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY: Washington County MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Alleghany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown c. LENGTH OF STAY IN 1b: 2 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westernport 0143-2
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital	d. STREET ADDRESS: 511 Maryland Ave. e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First: Marion	Middle: Marie	Last: Guy	4. DATE OF DEATH	Month: August	Day: 9	Year: 1959	
5. SEX: F.	6. COLOR OR RACE: W	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: Nov. 4, 1910	9. AGE (In years last birthday): 48 yrs.	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country): Maryland	12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: Charles Beeman		14. MOTHER'S MAIDEN NAME: Marion Nichol	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address: Eldridge Guy- Westernport, Md.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Pulmonary infarction + edema	2 days
DUE TO (b)	Non-bacterial endo carditis.	Several weeks
DUE TO (c)	Carcinoma of tail of pancreas & metastasis to liver & lung	Unknown

157x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Infarctions in spleen, Kidneys and brain.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21. I certify that I attended the deceased from August 7, 1959, to August 9, 1959, that I last saw the deceased alive on August 8, 1959, and that death occurred at 1355 M, from the causes and on the date stated above.

		ADDRESS (Street, city or town, state)	DATE SIGNED
ACTUAL SIGNATURE: A. F. Abdullah	M.D.	132 N. Potomac	
PHYSICIAN'S NAME (Type): A. F. Abdullah		Hagerstown, Md.	

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial	22b. DATE THEREOF: 8/12/59	22c. NAME OF CEMETERY OR CREMATORY: Philos Gem	22d. LOCATION (City, town, or county) (State): Westernport Md.	
23. FUNERAL DIRECTOR'S SIGNATURE: E. L. Beal	ADDRESS: Westernport, Md.	24a. REC'D BY REGISTRAR DATE: AUG 11 '59	24b. REGISTRAR'S SIGNATURE: Arthur L. Krauss	

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9639

CERTIFICATE OF DEATH

09585

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BOONSBORO
c. LENGTH OF STAY IN 1b: 10 YEARS
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: 35 SOUTH MAIN ST.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BOONSBORO
d. STREET ADDRESS: 35 SOUTH MAIN ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ESTIE Middle ANNIE Lost HARSHMAN

4. DATE OF DEATH: Month AUGUST Day 14. Year 19 59

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: OCTOBER 20 1877
9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months 9 Days 24
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE
10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME
11. BIRTHPLACE (State or foreign country): WOLFSVILLE FRED. Co. MD. U.S.A
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: LEVI BRANDENBURG
14. MOTHER'S MAIDEN NAME: LOUISE GROSSNICKLE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): NO
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: MRS. LUELLA KEPLER Address: BOONSBORO MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Generalized arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs
DUE TO (b): Hemorrhage from hiatus of Esophagus — 2 months
DUE TO (c):

450.0
Conditions, if ony, which gove rise to immediote couse (a), stating the underlying couse lost.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 1, 19 59, to Aug 14, 19 59, that I last saw the deceased alive on Aug 13, 19 59, and that death occurred at 4 P. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: G. Wilson M.D.
ADDRESS (Street, City or town, state): Boonsboro Md
DATE SIGNED: 8/15/59

PHYSICIAN'S NAME (Type): G. Wilson

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: AUG. 17. 1959
22c. NAME OF CEMETERY OR CREMATORY: GROSSNICKLE CEMETERY
22d. LOCATION (City, town, or county) (State): NR. MYERSVILLE FRED. Co. MD.

23. FUNERAL DIRECTOR'S SIGNATURE: John A. Bast
ADDRESS: BOONSBORO MD

24a. REC'D BY REGISTRAR DATE: AUG 24 '59
24b. REGISTRAR'S SIGNATURE: Charles J. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09586

9601

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 10 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Wash County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Maugansville
d. STREET ADDRESS: No North St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First KATHARINE Middle MAE Last HARTRANFT

4. DATE OF DEATH: Month August Day 25 Year 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov. 27 1897

9. AGE (In years last birthday): 61 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Secretary

10b. KIND OF BUSINESS OR INDUSTRY: McCauley & Cooey

11. BIRTHPLACE (State or foreign country): Fairview Wash Co Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Rev Saml D. Hardranft

14. MOTHER'S MAIDEN NAME: Sarah Minnich

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): -----

16. SOCIAL SECURITY NO.: 214-09-0249

17. INFORMANT: George R. Hartranft Address: 1069 Lincoln Way E Chambersburg Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Leukemia - acute — INTERVAL BETWEEN ONSET AND DEATH: 14 mo
DUE TO
(b)
DUE TO
(c)

2043

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 9, 1958 to Aug. 25, 1959, that I last saw the deceased alive on Aug 25, 1959, and that death occurred at 7:10 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Lloyd A. Hoffman M.D. ADDRESS (Street, city or town, state): 214 N. Potomac St. DATE SIGNED: 8/25/59

PHYSICIAN'S NAME (Type): Lloyd A. Hoffman Hagerstown, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8/27/59

22c. NAME OF CEMETERY OR CREMATORY: Dunkard Cemetery

22d. LOCATION (City, town, or county) (State): Broadfording Wash Co Md

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Andreww K. Coffman Hagerstown Md.

24a. REC'D BY REGISTRAR DATE: AUG 27 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9640

09587

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Boonsboro
c. LENGTH OF STAY IN 1b: 3 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Fahrney Keedy Memorial Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Frederick
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wolfsville 10X-2
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Jennie Middle: S. Last: Hays

4. DATE OF DEATH: Month: 8 Day: 12 Year: 1959

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 6/16/1875

9. AGE (In years last birthday): 84 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Joseph Stottlemyer

14. MOTHER'S MAIDEN NAME: Martha Hurley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Joe Hays, Myersville, Md. (Address)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Generalized arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs
DUE TO
450.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Fractured left hip — 3 weeks
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 22, 1959, to Aug 12, 1959, that I last saw the deceased alive on Aug 12, 1959, and that death occurred at 7:10 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: G. Wiltman M.D. ADDRESS (Street, city or town, state): Boonsboro Md DATE SIGNED: 8/13/59

PHYSICIAN'S NAME (Type): G. Wiltman

22a. BURIAL, CREMATION, REMOVAL (Specify): burial

22b. DATE THEREOF: 8/14/1959

22c. NAME OF CEMETERY OR CREMATORY: Lutheran Cemetery

22d. LOCATION (City, town, or county) (State): Wolfsville Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Gladhill Co., Middletown, Md.

24a. REC'D BY REGISTRAR DATE: AUG 17 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kroda

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9602

CERTIFICATE OF DEATH

Reg. Dist. No. 09588

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 10 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WASH. Co. HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): KEEDYSVILLE
d. STREET ADDRESS: MAIN ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First FRANKLIN Middle T. Last HODGES

4. DATE OF DEATH: Month AUGUST Day 29 Year 1959

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: SEPT 1 1872

9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months 11 Days 28
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PRINTER — GOVERNMENT PRINTING OFFICE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MONTGOMERY Co. MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM HODGES

14. MOTHER'S MAIDEN NAME: ELIZABETH WINDSOR

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: MRS. CLEO FLOOK — Address: KEEDYSVILLE MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Ruptured Gall Bladder & Peritonitis — INTERVAL BETWEEN ONSET AND DEATH: 3 weeks
DUE TO (b): Chronic Cholecystitis & Arteriosclerosis — 5 yrs. (?)
DUE TO (c):

584X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Nephrosclerosis with Uremia

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 17, 1959 to Aug 29, 1959, that I last saw the deceased alive on Aug. 29, 1959, and that death occurred at 5-PM from the causes and on the date stated above.

ACTUAL SIGNATURE: Walter H. Sheely M.D.
ADDRESS (Street, city or town, state):
DATE SIGNED: 8/31/59

PHYSICIAN'S NAME (Type): WALTER H. SHEALY M.D. SHARPSBURG, MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: SEPT. 1. 1959
22c. NAME OF CEMETERY OR CREMATORY: FAIRVIEW CEMETERY
22d. LOCATION (City, town, or county) (State): KEEDYSVILLE WASH. Co. MD

23. FUNERAL DIRECTOR'S SIGNATURE: John H. Bast
ADDRESS: BOONSBORO MD.

24a. REC'D BY REGISTRAR DATE: SEP 3 '59
24b. REGISTRAR'S SIGNATURE: Clinton S. Evans

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9603

09589

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 1 hr
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Wash. Co. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Pa. — b. COUNTY: Franklin ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Mercersburg 75 x 3
d. STREET ADDRESS: Route 2 - Mercersburg
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

081

3. NAME OF DECEASED (Type or print): First: William — Middle: Grant — Last: Hoffman
4. DATE OF DEATH: Month: Aug. — Day: 12 — Year: 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: June 16, 1884
9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming
10b. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (State or foreign country): Montgomery Twp.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Benjamin Hoffman
14. MOTHER'S MAIDEN NAME: Hettie Myers

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: -
17. INFORMANT: Mrs. Noble Pittman — Address: RD2 Mercersburg, Pa.

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MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): MYOCARDIAL INFARCTION — INTERVAL BETWEEN ONSET AND DEATH: 5 HOURS
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) ARTERIOSCLEROTIC CORONARY ARTERY SCLEROSIS WITH THROMBOSIS.
(c)

Thrombosis 5 hrs.
Sclerosis many years.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from September, 1939, to August 12, 1959, that I last saw the deceased alive on August 12, 1959, and that death occurred at 5:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: William C. Brewer M.D. — ADDRESS (Street, city or town, state): 359 E. Baltimore St., Greencastle, Pa. — DATE SIGNED: 8/13/59

PHYSICIAN'S NAME (Type): WILLIAM C. BREWER, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/15/59
22c. NAME OF CEMETERY OR CREMATORY: St. Thomas Cem.
22d. LOCATION (City, town, or county) (State): St. Thomas, Pa.

23. FUNERAL DIRECTOR'S SIGNATURE: A. E. Minnich — ADDRESS: Greencastle, Pa.
24a. REC'D BY REGISTRAR DATE: AUG 17 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

9641 **MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09590 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Fairplay, Md.
c. LENGTH OF STAY IN 1b: 4 month
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Boonsboro RFD #1 Md.

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Fairplay, Md.
d. STREET ADDRESS: Boonsboro Md. RFD #1
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: John — Middle: Frank — Last: Howard
4. DATE OF DEATH: Month: Aug. — Day: 27 — Year: 1959
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: Aug. 1 1929
9. AGE (In years last birthday): 30 yrs. — IF UNDER 1 YEAR: Months 0, Days 26 — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (State or foreign country): Sharpsburg Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A
13. FATHER'S NAME: Raymond C. Howard
14. MOTHER'S MAIDEN NAME: Edna Nichels
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): 1945-1948 2
16. SOCIAL SECURITY NO.: 220-26-0758
17. INFORMANT: Mr. Raymond Howard — Address: Sharpsburg Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Gunshot wound of chest — INTERVAL BETWEEN ONSET AND DEATH: instant

976X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Piercing Heart

DUE TO (c): Hemothorax right

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. EXTERNAL CAUSE WAS PRIMARY [X] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Gunshot wound of chest
20c. TIME OF INJURY: Hour: 6 a. m. / p. m. — Month, Day, Year: 8-27-59
20d. INJURY OCCURRED: While at work [ ] Not while at work [X]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town) Sharpsburg (County) Washington (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [X], Inquiry [ ], and find that death resulted from: Natural causes [ ], Accident [ ], Suicide [X], Homicide [ ], Undetermined cause [ ].

ACTUAL SIGNATURE: D. W. Otto M.D.
EXAMINER'S NAME (Type): DEWD H T O Jr
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
DATE SIGNED: 9/2/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug. 30-59
22c. NAME OF CEMETERY OR CREMATORY: Mt. View Cemetery
22d. LOCATION (City, town, or county) (State): Sharpsburg Maryland
23. FUNERAL DIRECTOR'S SIGNATURE: Albert L Leaf — ADDRESS: Williamsport Md
24a. REC'D BY REGISTRAR DATE: SEP 1 '59
24b. REGISTRAR'S SIGNATURE: Corinne S. Krauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9604

CERTIFICATE OF DEATH

09591

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1. PLACE OF DEATH a. COUNTY: Washington — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Md. b. COUNTY: Wash.
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown c. LENGTH OF STAY IN 1b: 45 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital	d. STREET ADDRESS: 1423 Virginia Ave. e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print)	First: Lula	Middle: Agnes	Last: Itneyer	4. DATE OF DEATH	Month: Aug.	Day: 16,	Year: 19 59	
5. SEX: female	6. COLOR OR RACE: white	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: Sept. 12, 1890	9. AGE (In years last birthday): 68 yrs.	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): seamstress	10b. KIND OF BUSINESS OR INDUSTRY: clothing store	11. BIRTHPLACE (State or foreign country): Union Bridge, Md.	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: William P. Young		14. MOTHER'S MAIDEN NAME: Carrie Stahl	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 213-12-7579	INFORMANT: Roy E. Itneyer, Address: Hagerstown, Md.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 month
420.1
DUE TO (b): Arteriosclerosis
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factary, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21. I **certify** thot I attended the deceased from 7/17, 1959, to 8/16, 1959, thot I last sow the deceosed alive on 8/15, 1959, and thot deoth occurred at 7:15 A M, from the causes and an the dote stated obave.

ACTUAL SIGNATURE: Robert V. h. Campbell M.D. — ADDRESS (Street, city or town, state): 145 W Washington St — DATE SIGNED: 8/17/59

PHYSICIAN'S NAME (Type): Robert V. h. Campbell — Hagerstown Md

22a. BURIAL, CREMATION, REMOVAL (Specify): burial	22b. DATE THEREOF: 8-19-59	22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery	22d. LOCATION (City, town, or county) (State): Hagerstown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Scott F. Minnich & Son, Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE: AUG 20 '59	24b. REGISTRAR'S SIGNATURE: Arthur S. Krause	

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9603

CERTIFICATE OF DEATH

9592

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 5 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 729 Orchard Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 729 Orchard Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOSEPH — Middle PARKER — Last JACKSON

4. DATE OF DEATH: Month August — Day 21 — Year 1959

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 15, 1923

9. AGE (In years last birthday): 36 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman

10b. KIND OF BUSINESS OR INDUSTRY: Cereal company

11. BIRTHPLACE (State or foreign country): Birmingham, Ala.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas S. Jackson

14. MOTHER'S MAIDEN NAME: Nell Mogridge

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes
(If yes, give war or dates of service): W.W.II

16. SOCIAL SECURITY NO.: 405-18-5903

17. INFORMANT: Mrs. Nell Jackson — Address: Hagerstown, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 day.
420.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Coronary sclerosis — 7
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Obesity.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from not seen 19 — to Aug 19 59, that I last saw the deceased alive on ____ 19 ____, and that death occurred at 4A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Richard T. Binford M.D. — ADDRESS (Street, city or town, state): 1135 Potomac ave — DATE SIGNED: 21 Aug 59

PHYSICIAN'S NAME (Type): Richard T. Binford — Hagerstown, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8/24/1959

22c. NAME OF CEMETERY OR CREMATORY: Zachary Taylor Cem.

22d. LOCATION (City, town, or county): Louisville (State): Kentucky

23. FUNERAL DIRECTOR'S SIGNATURE: Suter-Rouzer Funeral Home — R. Franklin Rouzer

ADDRESS: Hagerstown, Maryland

24a. REC'D BY REGISTRAR DATE: AUG 24 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9642

CERTIFICATE OF DEATH

05593

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Sharpsburg Md RFd
c. LENGTH OF STAY IN 1b: 87 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Antietam Furnace

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Sharpsburg Md RFD #1
d. STREET ADDRESS: Antietam Furnace
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First James — Middle — Last Jamison Jr.

4. DATE OF DEATH: Month Aug. — Day 29 — Year 19 59

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: March 21-1872

9. AGE (In years last birthday): 87 yrs.
IF UNDER 1 YEAR: Months 5 Days 7
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm Labor

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Antietam Furnace Md.

12. CITIZEN OF WHAT COUNTRY?: U. S. A

13. FATHER'S NAME: James Jamison Sr.

14. MOTHER'S MAIDEN NAME: Mary Crampton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: None

17. INFORMANT: George L. Jamison
Address: Antietam Furnace Sharpsburg Md RFD#1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Generalized arteriosclerosis. — INTERVAL BETWEEN ONSET AND DEATH: 10 Yrs

450.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chronic benign prostatic hypertrophy

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from August 1 19 58, to Aug. 31, 19 59, that I last saw the deceased alive on Aug. 28 59 and that death occurred at 8 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Walter H. Shealy M.D.
ADDRESS (Street, city or town, state): Sharpsburg, Md.
DATE SIGNED: 8/31/59

PHYSICIAN'S NAME (Type): WalterH. Shealy M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept. 1-59
22c. NAME OF CEMETERY OR CREMATORY: Mt. View Cemetery
22d. LOCATION (City, town, or county) (State): Sharpsburg Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Edith V. Long
ADDRESS: Williamsport Md.

24a. REC'D BY REGISTRAR DATE: SEP 1 '59
24b. REGISTRAR'S SIGNATURE: Esther S. Kraut

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: [illegible] this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

1

9606

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09594

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 33 Yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 209 West Irvin Ave

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 209 West Irvin Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: OMER — Middle: THOMAS — Last: KAYLOR Sr

4. DATE OF DEATH: Month: August — Day: 27 — Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 20 1885

9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Attorney at Law

10b. KIND OF BUSINESS OR INDUSTRY: Lawyer

11. BIRTHPLACE (State or foreign country): Hagerstown Wash Co Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas M. Kaylor

14. MOTHER'S MAIDEN NAME: Orbannah Fahrney

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): -----

16. SOCIAL SECURITY NO.: 217-12-2915

17. INFORMANT: Omer T. Kaylor Jr — Address: 940 The Terrace Hagerstown Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 20 min.
420.0
DUE TO (b): Arteriosclerotic heart disease — Indefinite
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. / p. m. — Month, Day, Year 19—

20d. INJURY OCCURRED: White at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 3, 1959 19— to death, 19—, that I last saw the deceased alive on July 26, 1959, 19—, and that death occurred at 6:00 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert F. Keadle M.D. — ADDRESS (Street, city or town, state): 318 N. Potomac St. — DATE SIGNED: 8-28-59

PHYSICIAN'S NAME (Type): Robert F. Keadle, M. D. — Hagerstown, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/30/59
22c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery
22d. LOCATION (City, town, or county) (State): Hagerstown Md. Wash Co

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Andrew K. Coffman Hagerstown Md.

24a. REC'D BY REGISTRAR DATE: SEP 1 '59

24b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9643

CERTIFICATE OF DEATH

09595

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Smithsburg rural
c. LENGTH OF STAY IN 1b: 50 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Own Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Smithsburg RD 1
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First Myrtle — Middle E. — Last Kendall

4. DATE OF DEATH: Month August — Day 13 — Year 19 59

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: Apr. 3, 1889

9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William Toms

14. MOTHER'S MAIDEN NAME: Clara Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 220-05-6770

INFORMANT: Lester W. Kendall — Address: Smithsburg RD1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 15min.
420.1
DUE TO
(b): Artersclerotic cardiovascular disease — 5 yrs.
Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8-30-54, 19____, to 8-13-59, 19____, that I last saw the deceased alive on 8-3-59, 19____, and that death accurred at 10:30 PM from the causes and an the date stated above.

ACTUAL SIGNATURE: Charles E. Hess, M.D. — ADDRESS (Street, city or town, state): Smithsburg, Md. — DATE SIGNED: 8-15-59

PHYSICIAN'S NAME (Type): Charles E. Hess

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8-16-59

22c. NAME OF CEMETERY OR CREMATORY: Smithsburg Cemetery

22d. LOCATION (City, town, or county) (State): Smithsburg, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Raymond E. Creager — ADDRESS: Thurmont, Md.
Raymond E. Creager

24a. REC'D BY REGISTRAR DATE: AUG 19 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

9607

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09596

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: Page 1 of this certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 10/57

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN MD
c. LENGTH OF STAY IN 1b: 15 MINUTES
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: WASH. Co. HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 HAGERSTOWN
d. STREET ADDRESS: 133 ELM ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN Middle LUTHER Last KINDALL

4. DATE OF DEATH: Month AUGUST Day 17 Year 1959

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: FEB. 5 - 1884

9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months 6 Days 12
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER

10b. KIND OF BUSINESS OR INDUSTRY: HOME CONSTRUCTION

11. BIRTHPLACE (State or foreign country): TREGO WASH. Co. MD.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: JOSEPH KINDALL

14. MOTHER'S MAIDEN NAME: MAGGIE KINDALL

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 220-09-9164

17. INFORMANT: M.T. EYLER — Address: 110 ELM ST. HAGERSTOWN MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiovascular Collapse — Interval: 1 hr
DUE TO
(b): Coronary Infarction — Interval: 2 hrs.
DUE TO
(c): Arterio Sclerosis - Gen — Interval: yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m.

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 17, 19 59, to July 17, 19 59, that I last saw the deceased alive on July 17, 19 59, and that death occurred at 2 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Louis E. Graff M.D.
ADDRESS (Street, city or town, state): 119 E. Antietam, Hagerstown Md.
DATE SIGNED: 8/18/59
PHYSICIAN'S NAME (Type): Louis E. GRAFF, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: AUG. 20. 1959

22c. NAME OF CEMETERY OR CREMATORY: REST HAVEN CEMETERY

22d. LOCATION (City, town, or county) (State): HAGERSTOWN MD.

23. FUNERAL DIRECTOR'S SIGNATURE: John H. Bast
ADDRESS: BOONSBORO MD.

24a. REC'D BY REGISTRAR DATE: AUG 24 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9644 Items 1,9 FilmG246 8-17-59 et

CERTIFICATE OF DEATH

Reg. Dist. No. 09597

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Hagerstown
c. LENGTH OF STAY IN 1b: 17 months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Private home Route # 2 Black Rock Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: 10 Maryland — b. COUNTY: Frederick
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural Myersville,
d. STREET ADDRESS: 2 Rt.# 2 Wolfsville
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First JAMES Middle E Last KLINE
4. DATE OF DEATH: Month August Day 7 Year 1959
5. SEX: male
6. COLOR OR RACE: white
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: March 10, 1875
9. AGE (In years last birthday): 83 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Own General farm
11. BIRTHPLACE (State or foreign country): Frederick Co. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: George Kline
14. MOTHER'S MAIDEN NAME: Susan Dubel
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: none
INFORMANT Address: Mrs. Ada Kline, Hagerstown, Md. Rt.# 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Coronary Occlusion	2 Hrs.
DUE TO		
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Generalized Arteriosclerosis	8 Yrs.
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Pulmonary Emphysema

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9-27, 1954, to 8-7, 1959, that I last saw the deceased alive on 7-24, 1959, and that death occurred at 1:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Charles F. Hess M.D. — ADDRESS (Street, city or town, state): Smithsburg, Md. — DATE SIGNED

PHYSICIAN'S NAME (Type): Charles F. Hess

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: July 10, 1959
22c. NAME OF CEMETERY OR CREMATORY: St. Mark's Lutheran
22d. LOCATION (City, town, or county) (State): Wolfsville, Fred. Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Paul F. Bittle ADDRESS: Paul F. Bittle, Myersville, Md.
24a. REC'D BY REGISTRAR DATE: AUG 13 '59
24b. REGISTRAR'S SIGNATURE: Cathryn L. Hess

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

1

9608

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09598
Reg. Dist. No.

M

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 50 YRS.
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION): WASHINGTON COUNTY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 HAGERSTOWN
d. STREET ADDRESS: 1440 GEORGE ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

081

3. NAME OF DECEASED (Type or print): First WILLIAM — Middle SHERMAN — Last KLINE

4. DATE OF DEATH: Month AUGUST — Day 16 — Year 19 59

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 7/4/1908

9. AGE (In years last birthday): 51 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

I

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED PAINTER

10b. KIND OF BUSINESS OR INDUSTRY: HOUSE PAINTING

11. BIRTHPLACE (State or foreign country): WEST VIRGINIA

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: LUKE C. KLINE

14. MOTHER'S MAIDEN NAME: ANNIE M. BOWERS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 220-10-3283

17. INFORMANT: MRS. MINNIE KLINE — Address: HAGERSTOWN MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): ~~Cerebral~~ Carcinoma of

150X

DUE TO (b): oesophagus — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

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20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 12, 19 59, to 16 Aug, 19 59, that I last saw the deceased alive on 16 Aug, 19 59, and that death occurred at 12:30 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: H.N. Weeks M.D. — ADDRESS (Street, city or town, state): 136 N. Potomac St. — DATE SIGNED

1

PHYSICIAN'S NAME (Type): DR. HOWARD N. WEEKS HAGERSTOWN MD

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 8/18/59

22c. NAME OF CEMETERY OR CREMATORY: ROSE HILL CEM.

22d. LOCATION (City, town, or county) (State): HAGERSTOWN MD.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: W. T. Norment, Hagerstown, Md

24a. REC'D BY REGISTRAR DATE: AUG 19 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Kramer

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9645

CERTIFICATE OF DEATH

09599

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): NEAR WILLIAMSPORT
c. LENGTH OF STAY IN 1b: 4 YEARS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: HOMEWOOD REFORMED CHURCH HOME

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X BOONSBORO
d. STREET ADDRESS: 1 POTOMAC ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First GEORGIANNA Middle — Last KNODE

4. DATE OF DEATH: Month AUGUST Day 15 Year 1959

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JANUARY 17 1889

9. AGE (In years last birthday): 70 yrs. IF UNDER 1 YEAR: Months 6 Days 28 IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY: NONE

11. BIRTHPLACE (State or foreign country): BOONSBORO WASH. Co.

12. CITIZEN OF WHAT COUNTRY? MD. U.S.A

13. FATHER'S NAME: WILLIAM E. KNODE

14. MOTHER'S MAIDEN NAME: GEORGIANNA SMITH

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: LEON MORGAN Address: BOONSBORO MD. R.1

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiovascular Collapse — INTERVAL BETWEEN ONSET AND DEATH: min.
DUE TO
(b): Coronary Occlusion — 2 WKS
DUE TO
(c): Arteriosclerosis — Yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8/7/ 19 59, to 19, that I last saw the deceased alive on 19, and that death occurred at M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Louis G. Graff M.D.
ADDRESS (Street, city or town, state): 119 E. Antietam St. Hagerstown Md.
DATE SIGNED: 8/12/59
PHYSICIAN'S NAME (Type): LOUIS G. GRAFF

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: AUG. 18-1959
22c. NAME OF CEMETERY OR CREMATORY: BOONSBORO CEMETERY
22d. LOCATION (City, town, or county) (State): BOONSBORO WASH. Co. MD.

23. FUNERAL DIRECTOR'S SIGNATURE: John H. Bast
ADDRESS: BOONSBORO MD.

24a. REC'D BY REGISTRAR DATE: AUG 24 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kinna

DR. HOWARD WEERS 136 N. Potomac

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9646

CERTIFICATE OF DEATH

Reg. Dist. No. 03600 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Williamsport Pike
c. LENGTH OF STAY IN 1b: 34 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Virginia Ave Extd

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Williamsport Pike, R #2
d. STREET ADDRESS: Virginia Ave Extd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Harriet; Middle: Elizabeth; Last: Landis

4. DATE OF DEATH: Month: Aug.; Day: 17; Year: 19 59

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov. 8-1882

9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Church Sect'y

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (State or foreign country): Berkley Co Marlowe, W. Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Landis

14. MOTHER'S MAIDEN NAME: Rebecca Ripple

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): ---
(If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Dr. Robert Liskey, Wmspt. Pike — Address: Virginia Ave Extd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 day
420.0
DUE TO
(b): Coronary artery disease — years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c): Arteriosclerotic heart disease — years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2 Dec, 1952 to 17 Aug, 1959, that I last saw the deceased alive on 17 Aug, 1959, and that death occurred at 6:45 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Richard T. Binford M.D.
ADDRESS (Street, city or town, state): 1135 POTOMAC AVE
DATE SIGNED: 18 Aug '59

PHYSICIAN'S NAME (Type): RICHARD T. BINFORD — HAGERSTOWN, MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/20/59
22c. NAME OF CEMETERY OR CREMATORY: Riverview Cemetery
22d. LOCATION (City, town, or county) (State): Washington Co Williamsport, Wash., Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Andrew K. Coffman, Hagerstown, Md.
ADDRESS

24a. REC'D BY REGISTRAR DATE: AUG 19 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

9609 **MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18** 09601

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 14 hrs.
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Washington Co. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Penna
b. COUNTY: Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Greencastle 75 x 3
d. STREET ADDRESS: Route #3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First George — Middle Raymond — Last Lesher

4. DATE OF DEATH: Month August — Day 21 — Year 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 7/28/1910
9. AGE (If years last birthday): 49 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Aircraft
10b. KIND OF BUSINESS OR INDUSTRY: Fairchill Aircraft
11. BIRTHPLACE (State or foreign country): Franklin Co. Penna
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Benjamin F. Lesher
14. MOTHER'S MAIDEN NAME: Eleanor Myers

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 219-14-7581
17. INFORMANT: Mrs. Elizabeth Lesher — Address: Greencastle, Pa

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Rheumatic Heart Disease, Chronic — INTERVAL BETWEEN ONSET AND DEATH: 35 yrs.
416X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9/1/—, 19 39, to 8/21/59, 19—, that I last saw the deceased alive on 8/21/59, 19—, and that death occurred at 2:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: W C Brewer M.D. — ADDRESS (Street, city or town, state): Greencastle, Pa. — DATE SIGNED: 8/22/59

PHYSICIAN'S NAME (Type): W C Brewer

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/24/1959
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
22d. LOCATION (City, town, or county) (State): Greencastle, Franklin Co. Penna

23. FUNERAL DIRECTOR'S SIGNATURE: Harold M. Zimmerman — ADDRESS: Greencastle, Pa
24a. REC'D BY REGISTRAR DATE: AUG 25 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1 X M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9610

CERTIFICATE OF DEATH

09602

Reg. Dist. No. 302

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

090

I

1. PLACE OF DEATH a. COUNTY: Washington — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE: Maryland — b. COUNTY: Washington
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown — c. LENGTH OF STAY IN 1b: 4 Mos	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Jackson Conv. Home	d. STREET ADDRESS: 134 W. Washington St — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First: GRACE	Middle: ROUSKULP	Last: LEWIS	4. DATE OF DEATH	Month, Day: August 4	Year: 1959
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: July 27 1877	9. AGE (In years last birthday): 82 yrs.	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife	10b. KIND OF BUSINESS OR INDUSTRY: Own Home	11. BIRTHPLACE (State or foreign country): Hagerstown Wash. Co Md.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Saml Edw Rouskulp		14. MOTHER'S MAIDEN NAME: Sarah Ellen Brill	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): ------	16. SOCIAL SECURITY NO.: None	17. INFORMANT: Mrs Helen Murray — Address: 320 So Mulberry St Hagerstown Md.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 3 days -

443X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Hypertensive - arteriosclerotic heart disease uncertain

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes mellitus - 21 years — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that I attended the deceased from 6/22, 19 42 to 8/4, 19 59, that I last saw the deceased alive on 8/4, 19 59, and that death occurred at 8:05 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: John H Hornbaker M.D. — ADDRESS (Street, city or town, state): 134 W. Washington, Hagerstown, Md. — DATE SIGNED: 8/5/59

PHYSICIAN'S NAME (Type): John H. Hornbaker

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	8/7/59	Rose Hill Cemetery	Hagerstown Wash Co Md.

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Andrew K. Coffman Hagerstown Md.	AUG 6 '59	Arthur L. Kruse

1

9647

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09603

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Washington MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hagerstown
c. LENGTH OF STAY IN 1b: 16 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Hagerstown
d. STREET ADDRESS Route 1
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print) First: Wilber Middle: Holland Last: Lewis

4. DATE OF DEATH: Month: August Day: 10 Year: 19 59

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: Feb. 28, 1887

9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm Owner

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Samples Manor Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Jerome T. Lewis

14. MOTHER'S MAIDEN NAME: Nannie V. Winks

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 219-14-8686

INFORMANT: Mrs. Anna B. Lewis Address: Hag. Rt. 1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Cardio Vascular Disease
DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH: 6 years

422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 4-1-59, 19___, to 8-10-, 1959, that I last saw the deceased alive on 8-7-59, 19___, and that death occurred at 7:10 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: E. W. Ditto M.D.

ADDRESS (Street, city or town, state): 215 W. Washington St

PHYSICIAN'S NAME (Type): Edward W. Ditto Jr.

Hagerstown Md.

DATE SIGNED: 8/11/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8-13-59

22c. NAME OF CEMETERY OR CREMATORY: Mt. View Cemetery

22d. LOCATION (City, town, or county) (State): Sharpsburg Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Scott F. Minnich & Son

ADDRESS: Hagerstown Md.

24a. REC'D BY REGISTRAR DATE: AUG 14 59

24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9611 Item 5 Film C246 8-21-59 et

CERTIFICATE OF DEATH

09604 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown, Md.
c. LENGTH OF STAY IN 1b: 45yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown, Maryland
d. STREET ADDRESS: 410 Sumans Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lurty — Middle: (None) — Last: Mack

4. DATE OF DEATH: Month: Aug — Day: 14 — Year: 19 59

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Mar 20 1888

9. AGE (In years last birthday): 71 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Janitor

10b. KIND OF BUSINESS OR INDUSTRY: City Hall

11. BIRTHPLACE (State or foreign country): Zenda, Va.

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Unknow

14. MOTHER'S MAIDEN NAME: Unknow

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-09-8213

17. INFORMANT — Address: Mrs. Ella Mack 410 Sumans Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinomatosis primary in Stomach. — INTERVAL BETWEEN ONSET AND DEATH: Months.

151X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerotic Cardiovascular Disease.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 22, 1959 to August 14, 1959 that I last saw the deceased alive on August 14, 1959, and that death occurred at 1:40 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: R.A. Bell M.D. — ADDRESS (Street, city or town, state): 119 N. Potomac Street — DATE SIGNED: 8-17-59

PHYSICIAN'S NAME (Type): R.A.Bell, M.D. — Hagerstown, Maryland.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8-17-1959

22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

22d. LOCATION (City, town, or county) (State): Hagerstown, Maryland,

23. FUNERAL DIRECTOR'S SIGNATURE: John R Watson Jr — ADDRESS: Hagerstown Md.

24a. REC'D BY REGISTRAR DATE: AUG 19 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

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9612

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09605

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: Washington MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Washington
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown; c. LENGTH OF STAY IN 1b: Life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 202 Summit Ave.	d. STREET ADDRESS: 202 Summit Ave. e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
	AGNES	IOLA	MARTIN		August	31	19 59

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married	Oct.6,1906	52 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Office work	Fairchild Aircraft	Hagerstown,Md.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Howard F.Stickler	Susie Crunkleton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	214-09-5394	Mr.M.F.Martin	202 Summit Ave.Hagerstown,Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of Colon — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.

153.8

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐ WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19 — 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2-6-57, 19 , to 8-31-59, 19 , that I last saw the deceased alive on Aug 31, 1959, and that death occurred at 10 45 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Paul Harrison M.D. — ADDRESS (Street, city or town, state): 318 N. Potomac St. Hagerstown, Md. — DATE SIGNED: 9-1-59

PHYSICIAN'S NAME (Type): Paul Harrison, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county)	(State)
Burial	9/3/59	Rest Haven Cemetery	Hagerstown	Md.

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
Rest Haven Funeral Chapel Inc.	Hagerstown,Md.	DATE SEP 3 '59	Arthur S. Kraus

Wm. A. Horst V-Pres.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9613

CERTIFICATE OF DEATH

09606
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY WASHINGTON MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY WASHINGTON

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN

c. LENGTH OF STAY IN 1b 60YRS.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 HAGERSTOWN

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL

d. STREET ADDRESS 16 S. MULBERRY ST.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First HIRAM Middle MAURICE Last McKINSEY

4. DATE OF DEATH Month AUGUST Day 21 Year 19 59

5. SEX MALE

6. COLOR OR RACE WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH 5/9/1892

9. AGE (In years last birthday) 67 yrs.

IF UNDER 1 YEAR Months Days

IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MOULDER

10b. KIND OF BUSINESS OR INDUSTRY SAND BLAST MACHINE CORP.

11. BIRTHPLACE (State or foreign country) MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME HIRAM McKINSEY

14. MOTHER'S MAIDEN NAME NETTIE WARBLE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 214-09-6047

17. INFORMANT MISS LOUISE McKINSEY Address HAGERSTOWN MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 1 day,

332X

DUE TO (b) Marked generalized arteriosclerosis — years,

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Old Myocardial infarction, Recent leg amputation;

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 20 June, 1957, to 20 aug, 1959, that I last saw the deceased alive on 20 aug, 1959, and that death occurred at 2 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE Richard T. Binford M.D. ADDRESS (Street, city or town, state) 1135 Potomac Avenue DATE SIGNED 21 August 1959

PHYSICIAN'S NAME (Type) RICHARD T. BINFORD, M. D. Hagerstown, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

22b. DATE THEREOF 8/23/59

22c. NAME OF CEMETERY OR CREMATORY SMITHSBURG CEM.

22d. LOCATION (City, town, or county) SMITHSBURG (State) MD.

23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment ADDRESS Hagerstown, Md.

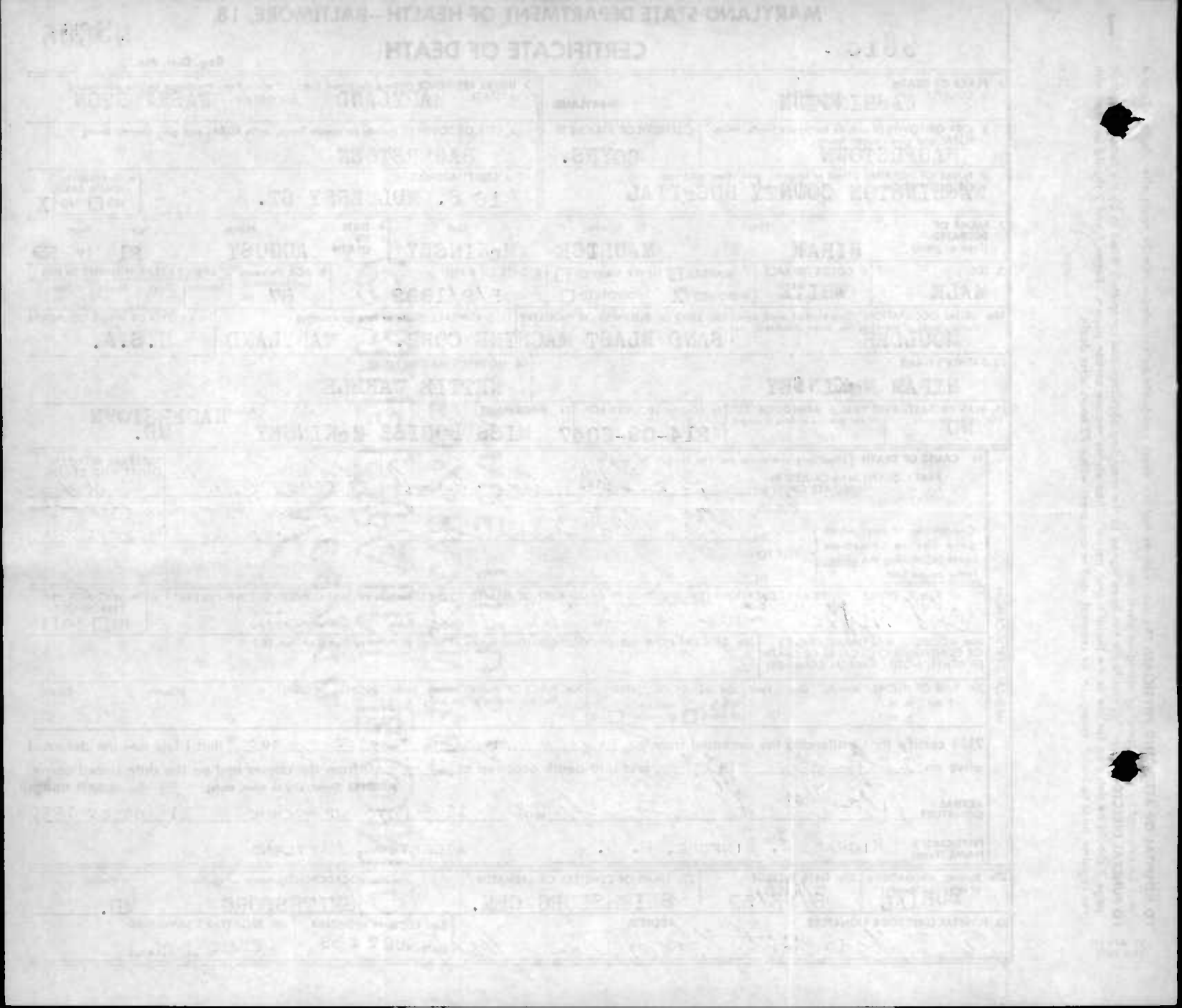
24a. REC'D BY REGISTRAR DATE AUG 24 '59

24b. REGISTRAR'S SIGNATURE Arthur L. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9607

CERTIFICATE OF DEATH

9614

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 2 Weeks
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Wash County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 537 West Church St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HELEN Middle REBECCA Last McNAMEE

4. DATE OF DEATH: Month August Day 21 Year 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 16 1894

9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR / IF UNDER 24 HRS. — Months / Days / Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Hagerstown Wash Co Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Harry G. Nail

14. MOTHER'S MAIDEN NAME: Betty E. Golden

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ——

16. SOCIAL SECURITY NO.: Unable to Locate

17. INFORMANT: Mrs Mildred Benchoff Address: Cascade Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 wks
DUE TO
(b): General arteriosclerosis — 10 yrs
DUE TO
(c): Cardiac decompensation

332 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Essential hypertension

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 6, 1959, to Aug 21, 1959, that I last saw the deceased alive on Aug 20, 1959, and that death occurred at 8:45 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Edward W. Ditto III M.D. — ADDRESS (Street, city or town, state): 217 W. Washington St — DATE SIGNED: 8/21/59

PHYSICIAN'S NAME (Type): Edward W. Ditto III — Hagerstown, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8/23/59

22c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery

22d. LOCATION (City, town, or county) (State): Hagerstown Wash Co Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Andrew K. Coffman Hagerstown Md.

24a. REC'D BY REGISTRAR DATE: AUG 25 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9615

CERTIFICATE OF DEATH

09608 Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

N

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081

1. PLACE OF DEATH a. COUNTY: WASHINGTON — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: MARYLAND b. COUNTY: WASHINGTON
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN — c. LENGTH OF STAY IN 1b: 30 YRS.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 HAGERSTOWN
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: WASHINGTON COUNTY HOSPITAL	d. STREET ADDRESS: 126 RANDOLPH AVE. — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
JOHN	WILLIAM	MILLS	AUGUST	5	19 59

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
MALE	WHITE		3/8/1892	67 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
RETIRED FARMER	OWN FARM	MARYLAND	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
ANDREW J. MILLS	FANNIE POFFENBERGER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
NO	214-09-8522	MRS. MARY T. MILLS	HAGERSTOWN MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) TOXEMIA — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO (b) Idiopathic Intestinal Obstruction — 3 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

570.5

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from August 5, 19 59 to August 5, 19 59, that I last saw the deceased alive on August 5, 19 59, and that death occurred at 5:45 P.M., from the causes and on the date stated above.

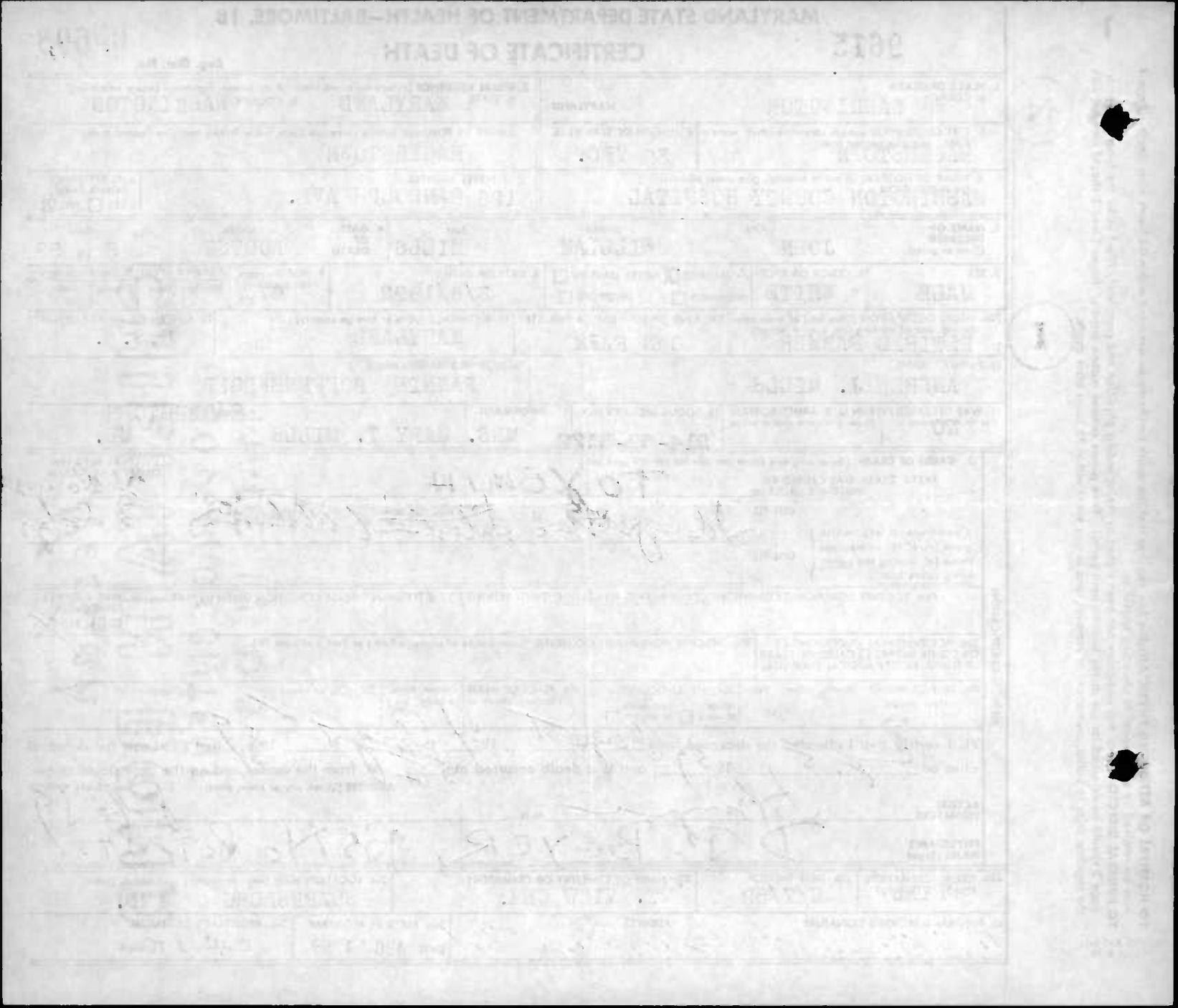
ACTUAL SIGNATURE [signature] M.D. — ADDRESS (Street, city or town, state) — DATE SIGNED 8-6-59

PHYSICIAN'S NAME (Type) D. J. BOYER, 135 No Pot. St.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
BURIAL	8/7/59	MT. VIEW CEM.	SHARPSBURG MD.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
W. J. Norment, Hagerstown, Md.	AUG 11 '59	Arthur S. Kinna

VS A1S (4)
15M 9/SS



1

9648

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09609

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RFD. Hagerstown, Md.
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Gateway Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: W. Va. b. COUNTY: Jefferson
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Shepherdstown 85x-3
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Fannie — Middle Bowly — Last Morgan

4. DATE OF DEATH: Month August — Day 1st — Year 1959.

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov. 20th 1893.

9. AGE (In years last birthday): 65 yrs.

IF UNDER 1 YEAR: Months 8 Days 11 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): RFD. Shepherdstown

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Augustine Charles Morgan (dec)

14. MOTHER'S MAIDEN NAME: Frances Russell Bowly, (dec)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Shepherdstown, W. Va. Mrs. Augusta Phillips (Sister)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Ac. Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: 3days
DUE TO (b): Cerebral Hem. — 3yrs.
DUE TO (c):

331x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 16, 1959 to Aug 1, 1959, that I last saw the deceased alive on July 31, 1959, and that death occurred at 6.20 M. from the causes and on the date stated above.

ACTUAL SIGNATURE: David R Brewer M.D.
ADDRESS (Street, city or town, state): Box 206 Clear Spring Md.
DATE SIGNED: 8/4/59
PHYSICIAN'S NAME (Type): David R. Brewer

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug. 5th '59.
22c. NAME OF CEMETERY OR CREMATORY: Elmwood
22d. LOCATION (City, town, or county) (State): Shepherdstown, W. Va.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Melvin T. Strider, Charlestown, W. Va.
24a. REC'D BY REGISTRAR DATE: AUG 10 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

(Dr. David Brewer, Clear Spring, Md.)

090

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9616

CERTIFICATE OF DEATH

09610

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD. b. COUNTY: WASH.

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 3 WEEKS
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X RURAL BIG SPRING

d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: JACKSON NURSING HOME
d. STREET ADDRESS: RURAL BIG SPRING
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

090

3. NAME OF DECEASED (Type or print): First CARRIE Middle E. Lost MURRAY
4. DATE OF DEATH: Month 8 Day 7 Year 1959

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: JAN 27, 1903
9. AGE (In years last birthday): 56 yrs.
IF UNDER 1 YEAR: Months 6 Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

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13. FATHER'S NAME: JAMES SHOEMAKER
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: NONE
INFORMANT: CHARLES H. MURRAY Address: BIG SPRING, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Coronary occlusion - due — INTERVAL BETWEEN ONSET AND DEATH: 5-4 hrs
420.0
DUE TO
Conditions, if any, which gave rise to immediate couse (o), stating the underlying couse last.
(b) to arteriosclerotic heart disease long
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 7, 1959, to Aug 7, 1959, that I last saw the deceased alive on Aug 7, 1959, and that death occurred at 6 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Edward W Ditto III M.D. ADDRESS (Street, city or town, state): 217 W. Washington St. DATE SIGNED: 8/7/59
PHYSICIAN'S NAME (Type): Edward W. Ditto III, MD Hagerstown, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 8/10/59
22c. NAME OF CEMETERY OR CREMATORY: STONE BRIDGE DUNKARD
22d. LOCATION (City, town, or county) (State): HANCOCK, MD.

23. FUNERAL DIRECTOR'S SIGNATURE: JOHN F. CLARK ADDRESS: CLEAR SPRING, MD.
24a. REC'D BY REGISTRAR DATE: AUG 13 '59
24b. REGISTRAR'S SIGNATURE: Esther L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. (Page 4 may be retained by the hospitol or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar priar to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

9617 — 09611 — Reg. Dist. No.

Washington Co.

1. PLACE OF DEATH — a. COUNTY: WESTERN Md. HOSPITAL, HAGERSTOWN, MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town):
c. LENGTH OF STAY IN 1b: June 1 - to Aug 25 1959
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 1500 PENNSYLVANIA

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) — a. STATE: Md. b. COUNTY: PR. GEO.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LAUREL, MARYLAND
d. STREET ADDRESS: Contee Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First BLANCHE Middle Last NASH
4. DATE OF DEATH: Month AUGUST Day 25 Year 1959

5. SEX: FEMALE
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Aug 5 - 1883
9. AGE (In years last birthday) 76 yrs.
IF UNDER 1 YEAR: Months ____ Days ____ IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10b. KIND OF BUSINESS OR INDUSTRY: Housekeeper
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Wilson Carey Selden
14. MOTHER'S MAIDEN NAME: Elizabeth Catherine Deimer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): ____
16. SOCIAL SECURITY NO.: 218-34-7269
INFORMANT: Mrs Celia Janoske Address: Laurel, Md

MEDICAL CERTIFICATION

1B. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CONFLUENT LOBULAR PNEUMONIA Lower Lobes Bilater — INTERVAL BETWEEN ONSET AND DEATH: 6 DAYS
200.1
DUE TO (b): RETROPERITONEAL LYMPHOSARCOMA — 9 MONTHS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying couse lost.
DUE TO (c): ____

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): PEPTIC ULCER OF STOMACH
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from JUNE 15, 1959, to AUG. 25, 1959, that I last saw the deceased alive on AUG. 25, 1959, and that death occurred at 5.55 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: George Berch. M.D. ADDRESS (Street, city or town, state): 1500 PENNSYLVANIA AVE DATE SIGNED: 8/25/59
PHYSICIAN'S NAME (Type): DR. GEORGE BERCH. HAGERSTOWN, MARYLAND.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug 27, 1959
22c. NAME OF CEMETERY OR CREMATORY: St Johns Cem
22d. LOCATION (City, town, or county) (State): Beltsville Md

23. FUNERAL DIRECTOR'S SIGNATURE: DeWitt Davidson ADDRESS: Laurel, Md
24a. REC'D BY REGISTRAR DATE: AUG 31 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/SB

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

9618 — 09612 — Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown Md.
c. LENGTH OF STAY IN 1b: 4 wks 3 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Williamsport Md RFD #1
d. STREET ADDRESS: Williamsport Md. RFD #1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Washington County Hospital

081

3. NAME OF DECEASED (Type or print): First: Lizzie — Middle: Minerva — Last: Nonemaker

4. DATE OF DEATH: Month: Aug. — Day: 5 — Year: 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: June 18 1881
9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months: 1 — Days: 17
IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Pa.
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Henry Stoner
14. MOTHER'S MAIDEN NAME: Emma Miller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: None
INFORMANT: Mrs. Florence Hosfeld — Address: Downsville Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonitis — INTERVAL BETWEEN ONSET AND DEATH: 2 dys
DUE TO (b): —
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): —

492X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Uremia
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour: o. m. / p. m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 1, 1959 to Aug 5, 1959 that I last saw the deceased alive on Aug 5, 1959, and that death occurred at 11 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE OF PHYSICIAN: M E Byrkit — M.D. — ADDRESS (Street, city or town, state): 28 W. Potomac — DATE SIGNED: 8/6/59
PHYSICIAN'S NAME (Type): M. E. Byrkit — Williamsport, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug. 8-59
22c. NAME OF CEMETERY OR CREMATORY: Mennonite Cemetery
22d. LOCATION (City, town, or county) (State): Clearspring Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Alvin Bitner — ADDRESS: Williamsport
24a. REC'D BY REGISTRAR DATE: AUG 7 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9649 — Item 7 FilmG248 9-8-59 et — 09613 — Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural 1 Hancock Md.
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Home

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural 1 Hancock Maryland
d. STREET ADDRESS: Rural 1 Hancock Maryland
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Allen — Middle: Andrew — Last: Norris
4. DATE OF DEATH: Month: 8 — Day: 25 — Year: 19 59
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: May 24.1915
9. AGE (In years last birthday): 44 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor Orchard
10b. KIND OF BUSINESS OR INDUSTRY: Labor Orchard
11. BIRTHPLACE (State or foreign country): Washington County Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John C Norris
14. MOTHER'S MAIDEN NAME: Minnie B Jerome
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 218-10-8997
17. INFORMANT — Address: Wilbur Trail Rural 1 Hancock Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 914.0
DUE TO (b): Electrocution
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: Instant

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Antenna Wire contact with high Voltage
20c. TIME OF INJURY: Hour: 7:00 a.m. p.m. — Month, Day, Year: 8-25-59
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town): Hancock (County): Wash (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE OF M.D.: [signature]
EXAMINER'S NAME (Type): [illegible]
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 8/26/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8.29.59
22c. NAME OF CEMETERY OR CREMATORY: Piney Plains Methodist Little Orleans Allegany
22d. LOCATION (City, town, or county) (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Howard F Stone Hancock md
24a. REC'D BY REGISTRAR — DATE: SEP 1 '59
24b. REGISTRAR'S SIGNATURE: Clifton S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9619

CERTIFICATE OF DEATH

09614

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md. — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Smithsburg
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

081

3. NAME OF DECEASED (Type or print): First Jacob — Middle — Last Pryor
4. DATE OF DEATH: Month Aug. — Day 24, — Year 19 59

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 9, 1887
9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): trackman
10b. KIND OF BUSINESS OR INDUSTRY: railroad
11. BIRTHPLACE (State or foreign country): Foxville, Md.
12. CITIZEN OF WHAT COUNTRY?

1

13. FATHER'S NAME: Upton Pryor
14. MOTHER'S MAIDEN NAME: Minerva Bearsnider

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 705-10-5307
17. INFORMANT: Lucy A. Pryor — Address: Smithsburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
(b): Generalized arteriosclerosis — 5 yrs.
DUE TO
(c):

420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

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20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1-3-55, 19____, to 8-24-59 19____, that I last saw the deceased alive on 8-24-59, 19____, and that death occurred at 7:00P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Charles F. Hess M.D. — ADDRESS (Street, city or town, state): Smithsburg, Md. — DATE SIGNED: 8-26-59

PHYSICIAN'S NAME (Type): Charles F. Hess, M.D.

1

22a. BURIAL, CREMATION, REMOVAL (Specify): burial
22b. DATE THEREOF: 8-27-59
22c. NAME OF CEMETERY OR CREMATORY: Smithsburg Cemetery
22d. LOCATION (City, town, or county) (State): Smithsburg, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Scott F. Minnich & Son, Smithsburg, Md.
24a. REC'D BY REGISTRAR DATE: AUG 28 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be mailed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9650

CERTIFICATE OF DEATH

Reg. Dist. No. 19615

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): NEAR FUNKSTOWN R
c. LENGTH OF STAY IN 1b: 15 YEARS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: HAGERSTOWN MD. R 3

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): NEAR FUNKSTOWN RURAL
d. STREET ADDRESS: HAGERSTOWN MD. R.3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First MARY Middle E Last REESE

4. DATE OF DEATH: Month AUGUST Day 17 Year 1959

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: SEPT. 8 - 1881

9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months 11 Days 9
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (State or foreign country): WASHINGTON County MD

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN SPESSARD

14. MOTHER'S MAIDEN NAME: MARTHA TRITLE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: ALBERT W. REESE HAGERSTOWN MD. R.3 (Address)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 422.1
DUE TO (b): Cardio Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 4 years
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 4-1-59, 19____, to 8-17, 1959, that I last saw the deceased alive on 8-16-59, 19____, and that death occurred at 2:15 A. M., from the causes and an the date stated abave.

ACTUAL SIGNATURE: A. W. Hewitt M.D. ADDRESS (Street, city or town, state): Hagerstown Md DATE SIGNED: 8/19/59

PHYSICIAN'S NAME (Type): ANDREW HEWITT, JR.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: AUG. 19. 1959

22c. NAME OF CEMETERY OR CREMATORY: BEAVER CREEK CEMETERY

22d. LOCATION (City, town, or county) (State): BEAVER CREEK WASH. Co. MD.

23. FUNERAL DIRECTOR'S SIGNATURE: John H. Bair ADDRESS: Boonsboro MD

24a. REC'D BY REGISTRAR DATE: AUG 24 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Frank

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. [illegible] may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9651

09616

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural -Clearspring
c. LENGTH OF STAY IN 1b: 6 weeks
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Gateway Convalescent Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Hancock
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EDITH — Middle GRACE — Last RINEHART

4. DATE OF DEATH: Month August — Day 11 — Year 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Nov 25, 1870

9. AGE (In years last birthday): 88 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Lucian B Brenner

14. MOTHER'S MAIDEN NAME: Mary Catherine Fiery

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: Mrs. Omer N Carryer — Address: Hancock Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 6 yrs
DUE TO
(b): General arteriosclerosis — 10 yrs
DUE TO
(c):

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 6, 1957, to Aug 11, 1959, that I last saw the deceased alive on Aug 7—59, 19, and that death occurred at M, from the causes and an the date stated above.

ACTUAL SIGNATURE: L. E. Hilton M.D. — ADDRESS (Street, city or town, state): Hagerstown Md — DATE SIGNED: Aug 12 59

PHYSICIAN'S NAME (Type): L E Hilton

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8/13/59

22c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery

22d. LOCATION (City, town, or county) (State): Hagerstown Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Suter & Rouzer Funeral Home — ADDRESS: Hagerstown Md.
Charles M Rouzer

24a. REC'D BY REGISTRAR DATE: AUG 17 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9620

CERTIFICATE OF DEATH

09617

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown
c. LENGTH OF STAY IN 1b: 6 wks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Western Maryland

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. — b. COUNTY Wash
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown
d. STREET ADDRESS: 1810 Chestnut ST
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

091

3. NAME OF DECEASED (Type or print): First Josephine — Middle Baumgardner — Last Rockwell

4. DATE OF DEATH: Month August — Day 8 — Year 1959

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 3, 1911

9. AGE (In years last birthday): 48 Yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Hagerstown, Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: R. W Baumgardner

14. MOTHER'S MAIDEN NAME: Elva Miller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: —

INFORMANT: Ray C. Rockwell — Address: Hagerstown Md.

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Edema and Congestion — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO (b) Generalized Carcinomatosis — U.N.Known
DUE TO (c) Squamous cell carcinoma of Neck — 2 years

191.4
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

2

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 26, 1959, to August 8, 1959, that I last saw the deceased alive on August 8, 1959, and that death occurred at 5:15 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Evaristo R. Lachapelle M.D. — ADDRESS (Street, city or town, state): 1500 Pennsylvania Ave — DATE SIGNED: 8-8-59

1

PHYSICIAN'S NAME (Type): Evaristo R. Lachapelle — Hagerstown, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug 11, 1959
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cem.
22d. LOCATION (City, town, or county) (State): Greencastle Pa.

23. FUNERAL DIRECTOR'S SIGNATURE: A. E. Minnich — ADDRESS: Greencastle, Pa

24a. REC'D BY REGISTRAR DATE: AUG 11 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. See page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/SB

1

9621 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09618

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Washington MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown
c. LENGTH OF STAY IN 1b Unk
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Western Maryland State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Frederick
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural RD#2 10 X-2
d. STREET ADDRESS Near Frederick
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First THELMA Middle CATHERINE Last SCHILL
4. DATE OF DEATH Month AUGUST Day 3 Year 1959
5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 16 Oct 1926
9. AGE (In years last birthday) 32 yrs.
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work
10b. KIND OF BUSINESS OR INDUSTRY At Home
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Lewis H. Ropp
14. MOTHER'S MAIDEN NAME Mollie E. Wadford

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 219-20-3660
INFORMANT Address John J. Schill (Same as item #2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH 10 DAYS

7546

DUE TO

Conditions, if any, which gave rise to immediate couse (a), stoting the underlying couse last.

(b) RIGHT MIDDLE CEREBRAL ARTERY THROMBOSIS — 94 DAYS

DUE TO

(c) COARCTATION OF AORTA (SURGICALLY CORRECTED) — LIFE

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

LEFT HEMIPARESIS. DIABETES MELLITUS.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I ottended the deceosed from JULY 6, 1959, to AUGUST 3, 1959 thot I lost saw the deceased alive on AUGUST 3, 1959, and that death accurred at 10.10 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE George Bercu M.D. ADDRESS (Street, city or town, state) 1500 PENNSYLVANIA AVE DATE SIGNED 8/3/59

PHYSICIAN'S NAME (Type) DR. GEORGE BERCU HAGERSTOWN, MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 8-6-59
22c. NAME OF CEMETERY OR CREMATORY Frederick Memorial Park
22d. LOCATION (City, town, or county) (State) Frederick, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS M. R. Etchison & Son, Frederick, Maryland
24a. REC'D BY REGISTRAR DATE AUG 7 '59
24b. REGISTRAR'S SIGNATURE Clifton L. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. [redacted] may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

9622

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09619
Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar priar to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 7 Days
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Pa.
b. COUNTY: Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, Waynesboro Pa. 75 x - 3
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Rosie — Middle: V. — Last: Shockey

4. DATE OF DEATH: Month: August — Day: 18, — Year: 19 59

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug. 23, 1895
9. AGE (In years last birthday): 63 yrs.
IF UNDER 1 YEAR: Months: Days: — IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Waynesboro Pa., #1
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Samuel Welsh
14. MOTHER'S MAIDEN NAME: Mary Ann Rock

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address: Mr. Elmer C. Shockey, Waynesboro Pa., #1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Uremia	8/12/59
602 x DUE TO		
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last. (b) DUE TO	Pyonephrosis	2 weeks
(c)	Renal Calculus	6 wks(app.)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8/12/59, 19____, to 8/18/59, 19____, that I last saw the deceased alive on 8/18/59, 19____, and that death occurred at 1:07 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: J. G. Warden, M.D. — ADDRESS (Street, city or town, state) — DATE SIGNED

PHYSICIAN'S NAME (Type): J. G. Warden, M. D. — 832 Potomac Ave., Hagerstown, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/21/59
22c. NAME OF CEMETERY OR CREMATORY: Mt. Zion
22d. LOCATION (City, town, or county) (State): Waynesboro #1, Franklin Pa.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Walter J. Howe, Waynesboro Pa

24a. REC'D BY REGISTRAR — DATE: AUG 24 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kline

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9652

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 5 FilmG248 9-3-59 et

09621

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural 1 Hancock Md.
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural 1 Hancock Maryland.
d. STREET ADDRESS: Rural 1 Hancock Maryland
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Goldie — Middle: Frances — Last: Trail

4. DATE OF DEATH: Month: 8 — Day: 25 — Year: 19 59

5. SEX: Female M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan.27.1905

9. AGE (In years last birthday): 54 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Housewife

11. BIRTHPLACE (State or foreign country): Washington County Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John C Norris

14. MOTHER'S MAIDEN NAME: Minnie B Jerome

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Wilbur Trail — Address: Rural 1 Hancock Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a):
DUE TO (b): Electrocution — Instant
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

914.0

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Antenna Wire contact with High Voltage

20c. TIME OF INJURY: Hour 7.30 ~~a.m.~~ p. m. — Month, Day, Year: 8-25 1959

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) Hancock (County) Wash. (State) Md

21. I certify that I took chorge of the remoins described above, held on Autapsy ☐, Inspectian ☒, Inquiry ☐, and find that death resulted from: Noturol couses ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Dr EW Dutt Jr M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): DR EW DUTT JR

DATE SIGNED: 8/26/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8.29.59

22c. NAME OF CEMETERY OR CREMATORY: Piney Plains Methodist

22d. LOCATION (City, town, or county): Little Orleans Allegany (State) Md

23. FUNERAL DIRECTOR'S SIGNATURE: Howard F Stone — ADDRESS: Hancock Md

24a. REC'D BY REGISTRAR — DATE: SEP 1 '59

24b. REGISTRAR'S SIGNATURE: Clifton E Kemp

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

9653 **MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

09622

CERTIFICATE OF DEATH

Reg. Dist. No.

M

1. **PLACE OF DEATH** a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Boonesboro
c. LENGTH OF STAY IN 1b: 4 months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Reeders Nursing Home

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural Hagerstown
d. STREET ADDRESS: Route 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Rosella — Middle: Catherine — Last: Turner

4. **DATE OF DEATH**: Month: August — Day: 2 — Year: 19 59

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Jan 4, 1875

9. AGE (In years last birthday): 84 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Elkton Va.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: James Dofflemyer

14. MOTHER'S MAIDEN NAME: Heneritta Woods

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: —

INFORMANT: Mrs. Russell Hartley — Address: Hagerstown Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic heart — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs
420.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I ar Part II of item 18.)

20c. TIME OF INJURY Haur a. m. p. m. Manth, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Nat while at work ☐

20e. PLACE OF INJURY (Hame, farm, factory, street, office bldg., etc.)

20f. (City ar tawn) (County) (Stote)

21. I **certify** that I attended the deceased from July 2, 19 59, to Aug 2, 19 59, that I last saw the deceased alive an Aug. 2, 19 59, and that death accurred at 11 A M. from the causes and an the date stated abave.

ACTUAL SIGNATURE: G W LeVan M.D.

ADDRESS (Street, city or town, stote): 33 S. Main St

DATE SIGNED: 8/3/59

PHYSICIAN'S NAME (Type): Gerald W. LeVan — Boonsboro Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8-4-59

22c. NAME OF CEMETERY OR CREMATORY: Dovels Cemetery

22d. LOCATION (City, town, or county) (Stote): Elkton Va.

23. FUNERAL DIRECTOR'S SIGNATURE: Scott F. Minnich & Son — ADDRESS: Hagerstown Md.

24a. REC'D BY REGISTRAR DATE: AUG 5 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. [redacted] may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9623

CERTIFICATE OF DEATH

09623 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 19 Yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 68½ E.Franklin St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First FLOYD — Middle MERLIN — Last VAUGHN

4. DATE OF DEATH: Month August — Day 15 — Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 16,1905

9. AGE (In years last birthday): 53 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Spray painter

10b. KIND OF BUSINESS OR INDUSTRY: Fairchild Aircraft

11. BIRTHPLACE (State or foreign country): Luray,Va.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph William Vaughn

14. MOTHER'S MAIDEN NAME: Alice Henry

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 217-18-7144

INFORMANT: Mrs.Floyd M.Vaughn — Address: 68½ E.Franklin St. Hagerstown,Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hemiplegia, left, due to Cerebral Throm-
DUE TO (b): bosis.
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

332 X

INTERVAL BETWEEN ONSET AND DEATH: 6 weeks.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 7, 1959 to Aug. 15, 1959 that I last saw the deceased alive on August 15, 1959, and that death occurred at 4:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: R.A.Bell M.D.
ADDRESS (Street, city or town, state): 119 N. Potomac Street, Hagerstown, Maryland.
DATE SIGNED: 8-17-59

PHYSICIAN'S NAME (Type): R.A.Bell, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/18/59
22c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery
22d. LOCATION (City, town, or county) (State): Hagerstown Md.

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Rest Haven Funeral Chapel Inc. Hagerstown,Md.

24a. REC'D BY REGISTRAR DATE: AUG 19 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

Wm. C. Hook V-Pres.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. [illegible] may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9624 (also 09624)

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 7 Mos
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Pipper Lane Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Hagerstown R # 2
d. STREET ADDRESS: Wright Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARGARET — Middle AVIS — Last WELLER

4. DATE OF DEATH: Month August — Day 17 — Year 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Jany 30 1898

9. AGE (In years last birthday): 61 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Charles Town Jefferson Co We Va

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Elmer Stonesifer

14. MOTHER'S MAIDEN NAME: Margaret Avis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ------

16. SOCIAL SECURITY NO.: 196-10-0654

17. INFORMANT: Address: Mrs Margaret A. Shuman Piper Lane Rd Hagerstown Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: four minutes
DUE TO
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) —
DUE TO
(c) —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 17, 19 59, to Aug 17, 19 59, that I last saw the deceased alive on ____, 19 59, and that death occurred at 1:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: M E Byrkit M.D. — ADDRESS (Street, city or town, state): 28 W Potomac St — DATE SIGNED: 8-18-59

PHYSICIAN'S NAME (Type): M. E. Byrkit — Williamsport Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/19/59
22c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery
22d. LOCATION (City, town, or county) (State): Hagerstown Wash Co Md

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Andrew K. Coffman Hagerstown Md.

24a. REC'D BY REGISTRAR DATE: AUG 19 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Mowa

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9625

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09625 Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 400 Michigan Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 1 400 Michigan Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ROY Middle IRVING Last WEST
4. DATE OF DEATH: Month August Day 12 Year 19 59
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept.26,1905
9. AGE (In years last birthday): 53 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Railroad
10b. KIND OF BUSINESS OR INDUSTRY: W.M.R.R.
11. BIRTHPLACE (State or foreign country): Hagerstown,Md.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: David Earl West
14. MOTHER'S MAIDEN NAME: Gertrude Pearl Baker
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 705-10-8629
17. INFORMANT: Mrs.Roy I.West Address: 400 Michigan Ave. Hagerstown,Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Gun shot wound of left — INTERVAL BETWEEN ONSET AND DEATH: Funeral

DUE TO (b): Chest

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 976 X

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Edward W. Ditto III M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): Edward W. Ditto III, M.D.
DATE SIGNED: 8/12/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/15/59
22c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery
22d. LOCATION (City, town, or county) (State): Hagerstown Md.
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Rest Haven Funeral Chapel Inc. Hagerstown, Md.
24a. REC'D BY REGISTRAR DATE: AUG 17 '59
24b. REGISTRAR'S SIGNATURE: Carlton S. Kline

Wm. A. Hook & Bro.

VS. A15ME(5)
5M 9/55

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate omitting the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME 5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9626 (09626) Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Wash. Co. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 133 John St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

099

3. NAME OF DECEASED (Type or print): First: William Middle: Marcus Last: Williams
4. DATE OF DEATH: Month: 8 Day: 2 Year: 19 59
5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb. 4, 1890
9. AGE (In years last birthday): 69 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired
10b. KIND OF BUSINESS OR INDUSTRY: carpenter
11. BIRTHPLACE (State or foreign country): Wash. Co. Md.
12. CITIZEN OF WHAT COUNTRY?: USA
13. FATHER'S NAME: Riley O. Williams
14. MOTHER'S MAIDEN NAME: Mary E. Carty
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 705-10-5884
17. INFORMANT: Mrs. Anna Williams Address: Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion
420.0
DUE TO (b): Arteriosclerotic Heart Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: instant

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

0

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour: o. m. p. m. Month, Day, Year: 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: J. E. Wolfe M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): J. E. WOLFE
DATE SIGNED: 8/3/59

2

22a. BURIAL, CREMATION, REMOVAL (Specify): burial
22b. DATE THEREOF: 8-5-59
22c. NAME OF CEMETERY OR CREMATORY: Rose Hill
22d. LOCATION (City, town, or county): Hagerstown (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Fred W. Kraiss ADDRESS: Hagerstown, Md.
24a. REC'D BY REGISTRAR DATE: AUG 5 '59
24b. REGISTRAR'S SIGNATURE: Esther L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9627

CERTIFICATE OF DEATH

Reg. Dist. No. 10755

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Pennsylvania — b. COUNTY: Fulton
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): McConnellsburg
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ORPHA — Middle: NMN — Last: WINTER

4. DATE OF DEATH: Month: August — Day: 31 — Year: 1959

5. SEX: Female — 6. COLOR OR RACE: White — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ — 8. DATE OF BIRTH: April 30, 1883 — 9. AGE (In years last birthday): 76 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife — 10b. KIND OF BUSINESS OR INDUSTRY: — 11. BIRTHPLACE (State or foreign country): Fulton Co. Pa. — 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Daniel B. Snyder — 14. MOTHER'S MAIDEN NAME: Jane Ann Peck

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): — 16. SOCIAL SECURITY NO.: — 17. INFORMANT Address: Daniel E. Winter, McConnellsburg, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 5 days

331X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Generalized arteriosclerosis — Uncertain
DUE TO (c): Hypertensive vascular disease — ? 8 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19 — 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6/11, 19 59 to 8/31, 19 59, that I last saw the deceased alive on 8/31, 19 59, and that death occurred at 8:40 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John M Thomas M.D. — ADDRESS (Street, city or town, state): 134 W. Washington St. Hagerstown Md. — DATE SIGNED: 9-1-59

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: Sept. 3, 59 — 22c. NAME OF CEMETERY OR CREMATORY: Tonoloway — 22d. LOCATION (City, town, or county) (State): Hancock, Md. RD

23. FUNERAL DIRECTOR'S SIGNATURE: H. H. Zinn — ADDRESS: Mercersburg, Pa. — 24a. REC'D BY REGISTRAR DATE: SEP 10 '59 — 24b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9628

CERTIFICATE OF DEATH

09627
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 6 YRS.
d. NAME OF HOSPITAL (If not in hospital, give street address): WASHINGTON COUNTY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
d. STREET ADDRESS: 120 BOWER AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: BOYD Middle: MIDDLETON Last: WOMACK

4. DATE OF DEATH: Month: AUGUST Day: 29 Year: 19 59

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7/21/1889

9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED SALESMAN

10b. KIND OF BUSINESS OR INDUSTRY: BAKERY SUPPLIES

11. BIRTHPLACE (State or foreign country): NORTH CAROLINA

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: W.J. WOMACK

14. MOTHER'S MAIDEN NAME: MINNIE ??

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 174-05-3761

INFORMANT: MRS. CATHERINE K. WOMACK Address: HAGERSTOWN MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO (b): Arterio sclerotic Heart Disease — ? 9 years
DUE TO (c):
420.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes mellitus. Arteriosclerosis Obliterans — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/22, 19 59, to 8/29, 19 59, that I last saw the deceased alive on 8/29, 19 59, and that death occurred at 11:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John H Hornbaker M.D. ADDRESS (Street, city or town, state): 154 West Washington St., Hagerstown, Md. DATE SIGNED: 8:31:59

PHYSICIAN'S NAME (Type): John H. Hornbaker, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 9/1/59
22c. NAME OF CEMETERY OR CREMATORY: ROSE HILL CEM.
22d. LOCATION (City, town, or county) (State): HAGERSTOWN MD.

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: W. J. Normant, Hagerstown Md.

24a. REC'D BY REGISTRAR DATE: SEP 2 '59
24b. REGISTRAR'S SIGNATURE: Arthur L Rinard

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9629

CERTIFICATE OF DEATH

09628
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: LIFE
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WASHINGTON COUNTY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MARYLAND — b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X RURAL HAGERSTOWN
d. STREET ADDRESS: RT.#5 HAGERSTOWN
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
MALINDA	MAE	ZEIGLER	AUGUSI	4	19 59

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
FEMALE	WHITE	NEVER MARRIED [X]	8/4/59	STILLBORN		5

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
INFANT		MARYLAND	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
DONALD J. ZEIGLER	BETTY JANE GROVE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address	
NO	NONE	MR. DONALD J. ZEIGLER	RT.#5 HAGERSTOWN MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Prematurity (about 7 months Gestation) — INTERVAL BETWEEN ONSET AND DEATH: 5 min.
776X
DUE TO: (heart beat about 5 minutes after birth)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Large meningocele was present (about size of egg)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from Aug. 4, 19 59 to Aug. 4, 19 59 that I last saw the deceased alive on Aug. 4, 19 59, and that death occurred at 5:00 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: R.A. Bell M.D.
ADDRESS (Street, city or town, state): 119 North Potomac Street
DATE SIGNED
PHYSICIAN'S NAME (Type): R.A.Bell, M.D. — Hagerstown, Maryland.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
BURIAL	8/5/59	REST HAVEN CEM.	HAGERSTOWN MD.

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
W. T. Norment, Hagerstown Md.		AUG 7 '59	Clifton S. Kraus

2081181XVO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55